STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURV COMPLETE
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/3/16 through 5/5/16. Complaints were investigated during the survey. Significant Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 169 certified bed facility was 151 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents #1 through #21 and #29) and 7 closed record reviews (Residents #22 through #28).	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 6/7/16

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change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to notify the physician of a change in condition for two of 29 residents in the survey sample, Residents # 22 and # 2.

1. The facility staff failed to notify the physician of Resident # 22's threat to harm herself.

2. The facility staff failed to notify the physician that Resident #2's medications were unavailable upon admission for dates 1/1/16 and 1/2/16.

The findings include:

1. Resident # 22 was admitted to the facility on 11/20/15 with a recent readmission on 3/18/16 with diagnoses that included but were not limited to: anemia, atrial fibrillation, congestive heart failure, hypertension, gastroesophageal reflux disease, renal insufficiency, hyperlipidemia, thyroid disorder, depression, and diabetes.

The most recent MDS (minimum data set) assessment, a Significant Change Assessment,

4. The Social Services Director or designee will conduct audits of residents threatening self-harm with each occurrence to assure the MD was notified timely. Unit Managers will conduct audits of new admission MARs and documentation to assure that the MD is notified when medications are not available. Audits of new admission MARs and documentation will be done five times weekly for four weeks, then randomly weekly for eight weeks. Reports of audits will be reported to the QA committee for review and revision as needed monthly for 3 months.
5. Date of compliance: June 2, 2016.

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with an assessment reference date of 3/25/16, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one person for all of her activities of daily living.

During an interview on 5/5/16 at 9:40 a.m. with OSM (other staff member) #10, an assistant in the business office, OSM # 10 reported that on 4/15/16 at approximately 3:10 p.m. while he was conducting room rounds Resident # 22 reported to him that she was in a lot of pain. OSM # 10 stated the resident's pain was in both of her legs. OSM # 10 further stated that he told the resident that he would check with the nurse (about pain medication). OSM # 10 stated that resident # 22 threatened to harm herself, "She would have to find something to hurt herself if she could not be helped with the pain." OSM # 10 said he told the resident, "No, don't do that; let me talk to the nurse and see if they can get you something for the pain." OSM # 10 then stated he went to Resident # 22's nurse [LPN (licensed practical nurse) # 15] and told him that she was in pain. OSM # 10 stated he did not remember telling the nurse about the threat only about the pain but when he returned from rounds to hand in his papers for rounds he definitely told RN (registered nurse) # 3, MDS nurse, and OSM # 12, a social worker, about Resident # 22's pain and her threat to hurt herself. OSM # 10 stated that he told the nurse (LPN # 15) only about the pain; this was confirmed in another interview with OSM # 10 on 5/5/16 at 11:30 a.m.

Review of Resident # 22's clinical record revealed no documentation that the physician had been

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notified that the resident had made a threat of self-harm.

During an interview on 5/5/16 at 9:55 a.m. with RN (registered nurse) # 4, the unit manager, on Resident # 22's unit, RN # 4 stated she was not aware of the Resident's threat. RN # 4 stated, she and ASM (administrative staff member) # 4, the physician, were doing rounds (at approximately 3:30 p.m. on 4/15/16) and were in the resident's room. Resident # 22 reported she had pain. RN # 4 stated she notified the charge nurse of the resident's pain. The physician was examining her. RN # 4 stated that Resident # 22 did not report that she (Resident # 22) might hurt herself.

An interview on 5/5/16 at 11:15 a.m. with LPN # 15 revealed the following: LPN # 15 only recalled she (Resident # 22) complained of mild pain and LPN # 15 medicated her with Tylenol* for that at about 2:40 p.m. LPN # 15 stated, "I do not recall anyone telling me that she had any pain or that she had threatened to hurt herself. I checked on the resident at approximately 3:20 p.m. and she was watching TV and had no complaints of pain at that time." LPN # 15 further stated the resident never mentioned hurting herself and no others told him she had made that threat. LPN # 15 stated if a threat had been made to him or reported to him, he (LPN # 15) "I would have been all over it."

During an interview on 5/5/16 at approximately 2:50 p.m. with ASM # 4, the physician, ASM # 4 stated, "No, I was not aware of any threat, she was on hospice and in a lot of pain. She (the resident) never indicated to me that she might hurt herself. No one came to (name of RN # 4) or

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I (ASM # 4) about a threat."

Review of the physician note dated 4/15/16 did not evidence any documentation of self harm statements by the resident or assessment of self injury behaviors for Resident #22.

Review of the clinical record revealed the following documentation: "Nursing Note, Note Text: 4/15/16 @ (at) 1531 (3:31 p.m.) resident called for pain med and oxycodone** 5 mg was given to resident. CNA (certified nurse's assistant) notified writer @ 1645 (4:45 p.m.) that resident had stabbed herself with scissors..."

Review of the facility policy: "Nursing-Notification of Changes" documented the following: "POLICY: It is the policy of this facility to inform the patient, consult with the patient's physician and notify the patient's legal representative or an interested family member when there is an accident, a significant change in the patient's physical, mental or psychosocial status, a need to alter treatment significantly, a decision to transfer or discharge patient from the facility..." Under "PROCEDURE:...2. Call the physician to advise and obtain orders..."

Review of the facility policy: "Suicide Prevention Plan" documented the following: "POLICY: it is the policy of this facility to provide a guideline, safety measures and treatments to patients who present a suicide risk. Patients who are actively suicidal cannot be cared for at FACILITY. Staff observing potential suicidal statements and behaviors exhibited by patients will report to supervisory staff immediately and take measures to promote safety." Under "PROCEDURE:...2. If a patient mentions suicidal ideation at any time,

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this is reported to the charge nurse, Director of Nursing, Social Worker and Physician to evaluate the threat. 3. All staff members are obligated to report suicidal statements or other indicators of possible ideation to their immediate supervisor. Supervisor to notify physician and psychologist..."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.

During an interview on 5/5/16 at 3:55 p.m. with ASM # 1, the Administrator, and ASM # 2, the Director of Nurses, this concern was reviewed.

Prior to exit no additional information was provided for this concern.

* Tylenol/Acetaminophen is used to relieve mild to moderate pain. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=tylenol

** Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: <https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/quer

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COMPLAINT DEFICIENCY
2. The facility staff failed to notify the physician that Resident #2's medications were unavailable upon admission for dates 1/1/16 and 1/2/16.

Resident #2 was admitted to the facility on 1/1/16 with diagnoses that included but were not limited to high blood pressure, type two diabetes mellitus, major depressive disorder, anxiety disorder, atrial fibrillation, colon cancer and lupus (an autoimmune disorder that attacks healthy tissues and cells affecting the joints, skin, blood vessels and organs (1)).

Resident #2's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/9/16. Resident #2 was coded as being cognitively impaired in the ability to make daily life decisions scoring 8 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #2 was coded as requiring extensive assistance with transfers, dressing, toileting, and bathing; and independent with meals.

Review of Resident #2's clinical record revealed Resident #2 arrived to the facility on 1/1/2016 at 2:45 p.m.

Review of Resident #2's POS (Physician Order Sheet) for January 2016 through May 2016 documented the following orders:
"Bimatoprost Solution 0.01 % Instill 1 drop in both eyes in the evening for GLAUCOMA" (Used for the management of glaucoma (2)).

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"Mirabegron ER (extended release) Tablet 24 HR (hour) Give 50 mg (milligrams) by mouth one time a day for HTN (high blood pressure)" (Used to treat overactive bladder (3) (a condition in which the bladder muscles contract uncontrollably and cause frequent urination, urgent need to urinate, and inability to control urination).
"PerserVision/Lutein (Multiple Vitamins-Minerals) Give 1 capsule by mouth two times a day for SUPPLEMENT" (Supplement to promote eye heath (4)).
"Azopt Suspension 1 % (Brimonidine Tablet) Instill 1 drop in both eyes two times a day for GLAUCOMA" (Used for the management of glaucoma (5)).
"Alphagan P Solution (Brimonidine Tartate) Instill 1 drop in both eyes two times a day for GLAUCOMA" (Used for the management of glaucoma (6)).
"Hydrocodone-Acetaminophen Tablet 7.5 mg -325 MG Give 1 tablet by mouth three times a day for PAIN" (Opioid analgesic used to decrease severity of moderate pain (7)).
Review of Resident #2's January 2016 MARS (Medication Administration Record) revealed Resident #2 was not given scheduled medications on 1/1/2016 and 1/2/16. The following medications were documented as "Not Done" on the January 2016 MARS:
- Bimatoprost 1 gtt(s) (drops) Ophthalmic (eye) Solution q.d. (every day) on 1/1/16 and 1/2/16 at 7:00 p.m.
- Mirabegron ER (extended release) 25 mg (milligrams) Oral Tablet on 1/2/16 at 9:00 a.m.
- PreserVision/Lutein (ADREDS [Age-Related Eye Disease Study]) 1 Capsule Oral Capsule b.i.d. (twice a day) on 1/2/16 at 8:00 a.m. and 4:00 p.m.
- Azopt 1 gtt(s) Ophthalmic Solution b.i.d. on

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1/2/16 at 8:00 a.m. and 4:00 p.m.
- Alphagan 1gtt(s) Opthalimc Solution b.i.d. on 1/2/16 at 8:00 a.m. and 4:00 p.m.
- Hydrocodone-Acetaminophen 7.5 mg-325 mg tablet: 1 Tablet Oral Tablet t.i.d (three times a day) on 1/1/16 at 10:00 p.m., 1/2/16 at 8:00 a.m., and 2:00 p.m.

Review of the emergency STAT (immediately) box list revealed that the above medications were not in the STAT box.

Review of the clinical record revealed a nurse's note dated 1/1/16 at 4:48 p.m. It documented the following: "Hard scripts received for Alprazolam (Xanax antianxiety medication (8)), Ceftin (antibiotic (9)), and Norco (Hydrocodone-Acetaminophen (10)). Per (name of doctor), orders followed from (Name of hospital) discharge summary and medications reconciled."

The next nurse's note dated 1/2/16 at 7:08 p.m., documented the following: "Late entry for 4:30. (Name of pharmacy), called in regards to medications, message left for on-call pharmacist, waiting return phone call."

No further nursing notes could be found regarding Resident #2's medications and no documentation evidenced the physician was notified of Resident #2's medication not being available.

Review of the pharmacy delivery manifest revealed that Resident #2's above medications arrived to the facility on 1/3/16 at 1:50 A.M.

On 5/5/16 at 8:40 a.m., an interview was

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conducted with RN (Registered Nurse) #1. When asked the process of ensuring medications are available for new admissions she stated, "The resident will come into the facility with a list of medications from the hospital; a hospital discharge summary." She stated that these orders are transcribed onto the facility's POS (Physician order Sheet) and faxed to pharmacy. She stated that the orders are reviewed with the physician before they are faxed to pharmacy. When asked the process if medications are not available at the scheduled time she stated, "Nursing would contact the pharmacy to let them know that the medications are not available. We would also check the STAT box to see if any medications are in there. If medications are not in the STAT box we would ask pharmacy to bring the medications on their next run." When asked if she would notify anyone if the medications were still not available she stated, "Yes the physician. He usually says give once medication available." She stated that the conversation with the MD (medical doctor) should be documented in the nurse's notes.

On 5/5/16 at 9:40 a.m., an interview was conducted with LPN #8, the nurse who wrote the note on 1/2/16 at 7:08 p.m. She stated that when a resident arrives to the facility nursing would fax orders to pharmacy and have them send it STAT (Immediately). She stated that if medications are still not available nursing would notify the physician. When asked if she could recollect the events on 1/1/16 and 1/2/16 for Resident #2, she stated, "That is my note but I am not sure why I got involved that night. I may have been the supervisor that night." She could not recollect if the physician was notified about Resident #2's medications.

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On 5/5/16 at approximately 12:30 p.m., ASM (administrative staff member) #3, the assistant director of nursing, stated that physician should be notified if medications are unavailable. She stated that the physician will usually give an order to give the medication when it arrives from pharmacy.

The floor nurse who worked 1/1/16 could not be reached for an interview.

No further documentation could be presented showing that the physician was notified about Resident #2's medications.

Facility policy called, "Nursing-Notification of Changes" documented in part, the following: "It is the policy of this facility to inform the patient, consult with the patient's physician and notify the patient's legal representative or an interested family member when there is an accident, a significant change in the patient's physical, mental, or psychosocial status, a need to alter treatment significantly..."

On 5/5/16 at 12:17 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.

(1) This information was obtained from the National Institutes of Health https://www.nlm.nih.gov/medlineplus/lupus.html
(2) This information was obtained from Davis's Drug Guide for Nurses p.1355.
(3) This information was obtained from The National Institutes of Health.

DEPARTMENT OF HEALTH AND H(AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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https://www.nlm.nih.gov/medlineplus/druginfo/meds/a612038.html.
(4) This information was obtained from The National Institutes of Health.
https://nei.nih.gov/amd/summary.
(5) This information was obtained from Davis's Drug Guide for Nurses p.1352.
(6) This information was obtained from Davis's Drug Guide for Nurses p.1357.
(7) This information was obtained from Davis's Drug Guide for Nurses p.637.
(8)This information was obtained from The National Institutes of Health.
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a684001.html
(9)This information was obtained from The National Institutes of Health.
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601206.html
(10) This information was obtained from The National Institutes of Health.
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601006.html

F 167 SS=C — 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE — F 167

A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.

The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.

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F 167	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure the most recent survey results for a revisit survey conducted 3/29/16, were readily available and accessible. The survey results were located in a binder labeled, "State Inspection Results." The binder was standing on the top of a table in the lobby. Review of the reports inside the binder documented, "Date Survey completed: 3/19/15, 1/6/16 and 3/3/16." The results of the survey ending 3/30/16 were not in the binder. The findings include: On 5/3/16 at 12:30 p.m., observation of the survey results was conducted. The survey results were located in a binder labeled "State Inspection Results." The binder was standing on the top of a table in the lobby. Review of the report inside the binder documented, "Date Survey completed: 3/19/15, 1/6/16 and 3/3/16." The results of the survey ending 3/30/16 were not in the binder. On 5/3/16 at 3:00 p.m., observation of the most recent survey results was conducted. The survey results were located in a binder labeled "State Inspection Results." The binder was standing on the top of a table in the lobby. Review of the report inside the binder documented, "Date Survey completed: 3/19/15, 1/6/16 and 3/3/16." The results of the survey ending 3/30/16 were not in the binder. On 5/3/16 at 3:15 p.m., an interview was	F 167	1. All residents were identified as being affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. The results of the facility's most recent survey were immediately placed in the binder in the front lobby. The Activities Director will notify residents and families of the location of survey results through the newsletter and during resident council meetings. 4. The receptionist will check the binder daily to assure that most recent survey results are present and that the binder is in the designated location. Any discrepancies will be reported to the Administrator immediately. 5. Date of Compliance: June 2, 2016	

DEPARTMENT OF HEALTH AND H(AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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conducted with ASM (administrative staff member) # 1, the administrator. When asked who was responsible for ensuring the most current survey results were available and accessible ASM # 1 stated, "It was the assistant administrator but he's no longer here so I guess it's me." After reviewing the binder labeled "State Inspection Results" ASM # 1 stated, "The results from the 3/20/16 revisit were scanned but not put in the book. We're looking for them."

On 5/3/16 at 3:30 p.m., ASM # 5, business office manager, provided this surveyor with a copy of the survey results dated 3/30/15. ASM # 5 stated, "We're putting it in the book now."

The facility's document entitled "Resident Rights" documented, "16. To be notified of the findings in any Centers for Medicare & Medicaid Services surveys and investigations concerning the facility."

On 5/4/16 at 6:20 p.m., ASM # 1, the administrator, and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was presented prior to exit.

F 276 SS=D — 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS — F 276

A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

This REQUIREMENT is not met as evidenced by:

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Based on staff interview and clinical record review, it was determined that facility staff failed to develop a quarterly assessment at least every three months for one of 29 residents in the survey sample; Resident #14.

The facility staff failed to develop a quarterly assessment for Resident #14, at the scheduled date of 4/11/16.

The findings include:

Resident #14 was admitted to the facility on 4/24/14 and readmitted on 3/3/16 with diagnoses that include but were not limited to anemia, heart failure, hyperlipidemia (high cholesterol), Alzheimer's Disease, Parkinson's Disease, osteoporosis, and under active thyroid.

Resident #14's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/11/16. Resident #14 was coded as being cognitively impaired in the ability to make daily life decisions scoring 3 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #14 was coded as requiring extensive assistance with transfers, dressing, toileting, and bathing; limited assistance with personal hygiene; and independent with meals.

Review of Resident #14's clinical record revealed her quarterly MDS assessment dated 1/11/16. The next assessment was a discharge/return anticipated assessment dated 2/15/16. Her last assessment observed was a 2/25/16 entry assessment. Resident #14's 4/11/16 quarterly MDS was not completed.

1. A quarterly assessment was scheduled and completed for Resident #14.
2. All residents with an MDS have the potential to be affected by this deficient practice.
3. The MDS Coordinator conducted a 100% audit to verify that each resident's MDS schedule is current. The Director of Nursing educated the MDS Coordinator on maintaining a current MDS schedule for each resident. The MDS Coordinator educated the MDS staff on maintaining a current schedule for each resident.
4. Random audits of resident MDS schedules will be conducted by the MDS Coordinator or designee weekly for four weeks then monthly for two months. Reports of all audits will be reported to QA committee for review and revision as needed monthly for 3 months.
5. Date of compliance: June 2, 2016.

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On 5/4/15 at 5:00 p.m., an interview was conducted with RN (Registered Nurse) #3, the MDS coordinator. She stated that Resident #14 was supposed have a quarterly assessment completed no later than 4/12/16. She stated, "It was not done. I am doing it now." RN #3 stated that she kept Resident #14 on the same assessment schedule because the resident did not have a significant change prior to leaving the facility. She stated that she uses the RAI (Resident Assessment Instrument) as a reference.

The MDS 3.0 RAI manual documents the following: "OBRA-required assessments are federally mandated and, therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in Items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting) - they include: Entry record, Admission (comprehensive), Quarterly, Annual (comprehensive) SCSA (comprehensive [Significant Change in Status Assessments]), SCPA (comprehensive [Significant Correction to a Prior Medicare Required Assessment]), SCQA (Significant Correction to Prior Quarterly Assessment), Discharge reporting, Discharge assessments - return not anticipated, return anticipated, Death in facility record."

Review of CMS's (Centers for Medicare and Medicaid Services) RAI version 3.0 manual dated October 2011, "Chapter 2: Assessment for the Resident Assessment Instrument", under the heading "05. Quarterly Assessment" documents, "The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act)

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non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored ... The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type."

On 5/5/16 at 12:17 p.m., ASM (Administrative Staff Member) #1, the administrator, was made aware of the above findings. No further information was presented prior to exit.

F 276

F 278 SS=D 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual

F 278

1. Section H of resident #1's MDS was corrected and submitted.

2. All residents with urinary catheters have the potential to be affected by this deficient practice.

3. The MDS Coordinator conducted a 100% audit of section H of the MDS for residents with urinary catheters to assure accurate coding. The MDS Coordinator educated MDS staff on accurate coding of section H for urinary catheters.

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to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for one of 29 residents in the survey sample; Resident #1.

The facility staff failed to accurately code the Foley catheter status of Resident #1 on the quarterly MDS assessment with an ARD (assessment reference date) of 3/16/16.

The findings include:

Resident #1 was admitted to the facility on 8/1/13 with the diagnoses of but not limited to epilepsy, below knee amputation, high blood pressure, respiratory failure, stroke, pressure sore, and feeding tube.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/16/16. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, eating, and dressing; extensive assistance for bed mobility and hygiene; and was coded as

4. Audits of MDS for residents with urinary catheters will be conducted by the MDS Coordinator or designee weekly for four weeks; then random audits weekly for eight weeks for accuracy. Results of audits will be taken to the QA committee for review and revision as needed monthly for three months.

5. Date of compliance: June 2, 2016.

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incontinent of bowel and bladder.

On 5/3/16 at 3:35 p.m., 5/4/16 at 9:32 a.m., and 5/5/16 at 9:40 a.m., observations were made of Resident #1. He was lying in bed, with a Foley* catheter bag hanging on the side of the bed frame.

Review of the clinical record revealed a readmission nursing note dated 3/7/16 that documented, "....16FR (french, a form of measurement) / 5cc (cubic centimeters) foley in place and clear yellow urine noted to tubing and present in bag...."

A nurse's note dated 3/8/16 documented, "....Resident has a urinary catheter. Foley catheter in place. Catheter is patent and draining..."

A nurse's note dated 3/17/16 documented, "....Foley patent...."

Further review of the above identified MDS revealed under Section H "Bladder and Bowel" revealed Resident #1 was coded in Section H0100 Appliances, as "None of the above" (Check A for indwelling catheter, B for external catheter, C for Ostomy, D for intermittent catheterization, or Z for none of the above.)

In addition, Section H0300 Urinary Continence was checked for "Always Incontinent" (Check 0 for Always continent, 1 for Occasionally incontinent, 2 for Frequently incontinent, 3 for Always incontinent or 9 for Not rated, resident has a catheter...).

On 5/5/16 at approximately 10:00 a.m., in an

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interview with LPN #16 (Licensed Practical Nurse, the MDS nurse) she stated that the presence of the Foley was missed when reviewing nurses notes to complete the MDS assessment, and therefore the MDS was coded wrong. When asked about what policy the facility uses, she stated the RAI Manual (Resident Assessment Instrument).

According to the RAI Manual:

Coding Instructions
Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days.
- H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube)
- H0100B, external catheter
- H0100C, ostomy (including urostomy, ileostomy, and colostomy)
- H0100D, intermittent catheterization
- H0100Z, none of the above

Coding Tips and Special Populations
- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- Condom catheters (males) and external urinary pouches
(females) are often used intermittently or at night only; these should be coded as external catheters.
- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one time catheterization for urine specimen during look back period as intermittent catheterization.

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On 5/5/16 at 11:00 a.m., the Assistant Director of Nursing ADON, Administrative Staff #3) were made aware of these findings. At 3:43 p.m., the DON (Director of Nursing, Administrative Staff #2) stated there was no other information regarding the presence of the Foley at admission.

*According to Fundamentals of Nursing Lippincott Williams and Wilkins page 593.
"An indwelling urinary catheter also called a Foley catheter, provides the patient with continuous urine drainage. It is a latex or silicone tube which is inserted into the bladder and a small balloon is inflated at the catheter's distal end to prevent it from slipping out. A catheter is used for numerous reasons, but usually when there is a problem resulting in the inability to pass urine, such as in an obstruction or neurological (nerve, brain or spinal cord) disease or injury..."

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

F 279

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and

1. A care plan for dental needs was developed for Resident #7.
2. All residents who trigger the dental CAA have the potential to be affected by this deficient practice.
3. The MDS Coordinator conducted a 100% audit of residents who triggered the dental

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psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on staff interview, and clinical record review, staff failed to develop a complete comprehensive care plan for one of 29 residents in the survey sample; Resident #7.

Resident #7 triggered to be care planned for dental needs on his 1/27/16 annual comprehensive MDS (minimum data set) assessment. A care plan for dental needs was not developed.

The findings include:

Resident #7 was admitted to the facility on 2/23/15 with the diagnoses of but not limited to dementia, chronic obstructive pulmonary disease, high blood pressure, diabetes, colon cancer, cataracts, and Parkinson's disease.

The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 1/27/16. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for transfers, dressing, hygiene, and bathing; supervision for eating; and was coded as incontinent of bowel and bladder.

F 279

CAA to assure that a care plan for dental needs was developed. The MDS Coordinator educated MDS staff and IDT on the process of developing a care plan to address triggered CAAs.

4. Random audits of resident comprehensive assessments will be conducted by the MDS Coordinator or designee weekly for three weeks and monthly for two months to assure care plan development for triggered CAAs. Results of audits will be taken to QA committee for review and revision as needed monthly for two months.
5. Date of compliance: June 2, 2016.

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A review of the above identified MDS revealed in Section V, Care Area Assessment (CAA) Summary, the resident was triggered for the area of "Dental" in Column A (Care Area Triggered). In Column B (Care Planning Decision) this was marked with an "x" to indicate this area was to be care planned. A review of the care plan failed to reveal any evidence that dental was care planned. {Note: On Resident #7's MDS assessment of 1/27/16, Section L "Oral/Dental Status", the resident was coded with an "x" in the box next to "B. No natural teeth or tooth fragment(s) (edentulous).")

Review of the residents care plan failed to reveal one for dental.

On 5/5/16 at approximately 10:00 a.m., in an interview with LPN #16 (Licensed Practical Nurse, the MDS nurse) she stated that the dental care plan was missed. When asked what policy the facility uses, she stated the RAI Manual (Resident Assessment Instrument).

The following is taken from Section V of the MDS-Version 3.0:
"Section V: Care Area Assessment: V0200. CAAs and Care Planning
1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed Care Plan column must be completed within 7 days of completing the RAI [MDS and CAA(s)]. Check column B if the triggered care area is addressed in the care plan."

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Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care.

On 5/5/16 at 11:00 a.m., the Assistant Director of Nursing ADON, Administrative Staff #3) was made aware of the findings. At 3:43 p.m., the DON (Director of Nursing, Administrative Staff #2) stated there was no other information.

F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP — F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility

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for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 29 residents in the survey sample; Residents #1 and #2.

1. The facility staff failed to revise the comprehensive care plan to reflect the presence of a Foley catheter upon return from a hospitalization on 3/7/16 for Resident #1.

2. The facility staff failed to update Resident #2's comprehensive care plan after an order to float bilateral heels was initiated on 3/24/16.

The findings include:

1. The facility staff failed to revise the comprehensive care plan to reflect the presence of a Foley catheter upon return from a hospitalization on 3/7/16 for Resident #1.

Resident #1 was admitted to the facility on 8/1/13 with the diagnoses of but not limited to epilepsy, below knee amputation, high blood pressure,

1. The Care Plans of residents #1 and #2 were reviewed and revised. Resident #1's care plan was revised to reflect the presence and care of a urinary catheter. The Care Plan of resident #2 was corrected.
2. All residents with urinary catheters and orders to float heels have the potential to be affected by this deficient practice.
3. A 100% audit of care plans of residents with urinary catheters was completed to assure the catheters were care planned correctly. A 100% audit of care plans of residents with orders to float bilateral heels was conducted to assure that the float heels intervention was care planned correctly. The MDS Coordinator educated MDS staff on proper development, revision and review of a care plan for urinary catheters and the MD-ordered intervention of floating bilateral heels.
4. Audits of care plans of residents with urinary catheters and the MD-ordered intervention of floating bilateral heels will be completed weekly by the MDS Coordinator or designee for four weeks and then randomly for two months to assure compliance. Results of audits will be reported to the QA committee for review

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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPL(OAT

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respiratory failure, stroke, pressure sore, and feeding tube.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/16/16. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, eating, and dressing; extensive assistance for bed mobility and hygiene; and was coded as incontinent of bowel and bladder.

On 5/3/16 at 3:35 p.m., 5/4/16 at 9:32 a.m., and 5/5/16 at 9:40 a.m., observations were made of Resident #1. He was lying in bed, with a Foley* catheter bag hanging on the side of the bed frame.

Review of the clinical record revealed a readmission nursing note dated 3/7/16 that documented, "....16FR (french, a form of measurement) / 5cc (cubic centimeters) foley in place and clear yellow urine noted to tubing and present in bag...."

A nurse's note dated 3/8/16 documented, "....Resident has a urinary catheter. Foley catheter in place. Catheter is patent and draining..."

A nurse's note dated 3/17/16 documented, "....Foley patent...."

A nurse's note dated 4/4/16 documented, "...Foley care this shift without s/s (signs and symptoms) of discomfort..."

A nurse's note dated 4/7/16 documented,

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and revision as needed monthly for two months.

5. Date of compliance: June 2, 2016

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"...Resident has a urinary catheter. Foley catheter in place. Catheter is patent and draining..."

Review of Resident #1's comprehensive care plan failed to reveal any identification of the presence of, and goals and interventions and care needed for the use of a Foley catheter.

On 5/5/16 at 9:43 a.m., in an interview with LPN #10 (Licensed Practical Nurse) she stated that the presence of the Foley was present on readmission and should have been care planned to meet the resident's needs. She stated he did not have a Foley prior to hospitalization and this was a new concern for him.

A review of the Facility policy titled, "Care Plan-Interdisciplinary Team" documented, "It is the policy of this facility that the care plan/interdisciplinary team develop a comprehensive assessment and care plan for each patient that includes measurable objectives, and timetables to meet the patient's medical, nursing, nutritional, emotional, spiritual and psychological needs."

On 5/5/16 at 11:00 a.m., the Assistant Director of Nursing ADON, (Administrative Staff #3) was made aware of the findings. At 3:43 p.m., the DON (Director of Nursing, Administrative Staff #2) stated there was no other information regarding the presence of the Foley at admission.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of

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care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

*According to Fundamentals of Nursing Lippincott Williams and Wilkins page 593.
"An indwelling urinary catheter also called a Foley catheter, provides the patient with continuous urine drainage. It is a latex or silicone tube which is inserted into the bladder and a small balloon is inflated at the catheter's distal end to prevent it from slipping out. A catheter is used for numerous reasons, but usually when there is a problem resulting in the inability to pass urine, such as in an obstruction or neurological (nerve, brain or spinal cord) disease or injury..."

2. The facility staff failed to update Resident #2's comprehensive care plan after an order to float bilateral heels was initiated on 3/2/16.

Resident #2 was admitted to the facility on 1/1/16 with diagnoses that included but were not limited to high blood pressure, type two diabetes mellitus, major depressive disorder, anxiety disorder, atrial fibrillation, colon cancer and lupus (an autoimmune disorder that attacks healthy tissues and cells affecting the joints, skin, blood vessels and organs (1)).

Resident #2's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/9/16. Resident #2 was coded as being moderately

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cognitively impaired in the ability to make daily life decisions scoring 8 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #2 was coded as requiring extensive assistance with transfers, dressing, toileting, and bathing; and independent with meals.

Review of Resident #2's POS (Physician Order Sheet) dated 5/1/16 revealed the following active order, "Float Heels while in bed for prevention." This order was initiated on 03/02/2016.

Review of Resident #2's comprehensive care plan dated 1/29/16 documented the following: "Skin Integrity Needs ...Float heels-on pillows while in bed as tolerated by resident. Check placement each shift q (every shift) (Started January 6, 2016-continuing).

Review of Resident #2's revised care plan dated 3/24/16 did not have "Float Heels" as an intervention for focus area, "Impaired skin integrity."

On 5/5/16 at 7:55 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #6 regarding updating resident care plans. LPN #1 stated the care plan was updated for a change in condition or if the resident has a new order. She stated the nurses were responsible for updating the care plan. When asked if Resident #2 should have a care plan for the order to float heels, she stated, "If there is an order, yes, it should be on the care plan."

On 5/5/16 at 8:55 a.m., an interview was conducted with RN (Registered Nurse) #3, the MDS nurse. When asked who was responsible for updating the care plan she stated, "That could

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be a variety of people. Anyone who takes off an order should update the care plan. The floor nurses, unit managers and anyone in MDS can update the care plan. When asked if Resident #2's order to float bilateral heels should have been on the care plan she stated, "Yes and I don't see it on the care plan. Anyone could have been responsible for that. I will correct that."

On 5/5/16 at 9:40 a.m., an interview was conducted with LPN #8. LPN #8 stated, "Any nurse can update the care plan. It is usually the nurse who writes or initiates a new order." LPN #8 stated, "We update the care plan quarterly or with any new changes. Nursing does not look at the care plan every day but anyone can use it to see what the resident needs."

The facility policy titled, "Care Plan-Interdisciplinary Team" documented the following: "It is the policy of this facility that the care plan/interdisciplinary team develop a comprehensive assessment and care plan for each patient that includes measurable objectives, and timetables to meet the patient's medical, nursing, nutritional, emotional, spiritual and psychological needs."

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care

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plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

On 5/5/16 at 12:17 p.m., ASM #1 was made aware of the above concerns. No further information was provided prior to exit.

(1) This information was obtained from the National Institutes of Health https://www.nlm.nih.gov/medlineplus/lupus.html

F 314 SS=D 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES F 314

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having

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pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to implement physician ordered preventive measures for the development of pressure sores for one of 29 residents in the survey sample; Resident #2.

The facility staff failed to float Resident #2's bilateral heels on a pillow while she was lying in bed. Resident #2 was identified as a high pressure ulcer risk on her last skin assessment dated 1/1/2016.

The findings include:

Resident #2 was admitted to the facility on 1/1/16 with diagnoses that included but were not limited to high blood pressure, type two diabetes mellitus, major depressive disorder, anxiety disorder, atrial fibrillation, colon cancer and lupus (an autoimmune disorder that attacks healthy tissues and cells affecting the joints, skin, blood vessels and organs (1)).

Resident #2's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/9/16. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily life decisions scoring 8 out of 15 on the BIMS (Brief

1. Resident was assessed and the intervention of heel-float boots was implemented.
2. All residents with physician-ordered devices for the prevention of pressure ulcers have the potential to be affected by this deficient practice.
3. The Director of Nursing or designee educated nursing staff on implementing physician-ordered devices for the prevention of pressure ulcers.
4. Random observations of residents with physician-ordered devices for the prevention of pressure ulcers will be conducted five times a week for four weeks then randomly weekly for three months by Unit Managers or designee to assure that ordered measures have been implemented. Results of audits will be taken to the QA committee for review and revision as needed monthly for two months.
5. Date of compliance: June 2, 2016.

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Interview for Mental Status). Resident #2 was coded as requiring extensive assistance with transfers, dressing, toileting, and bathing; and independent with meals.

On 5/4/16 the following observations were made:

- 9:30 a.m., Resident #2 was lying in her bed. Her heels were resting directly on the mattress. Her heels were not floated.

- 10:00 a.m., Resident #2 was lying in her bed. Her heels were resting directly on the mattress. Her heels were not floated. When Resident #2 was asked if nursing staff elevate her feet on a pillow, she stated, "Sometimes they do."

On 5/4/16, at 10:18 a.m., wound care observation was conducted for Resident #2. Resident #2 had a (2) stage II sacral pressure sore (a partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister). Pressure sores are areas of damaged skin caused by staying in one position for too long. They commonly form where your bones are close to your skin, such as your ankles, back, elbows, heels and hips.(3)) Upon completion of wound care, LPN (licensed practical nurse) #6, left Resident #2's room without floating her heels.

On 5/5/16 at 8:55 a.m., Resident #2 was observed lying in bed. Her heels were lying directly on the mattress. Resident #2 stated that she was having bilateral pain in her feet.

Review of Resident #2's POS (Physician Order Sheet) dated 5/1/16 revealed the following active

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order, "Float Heels while in bed for prevention." This order was initiated on 03/02/2016.

Review of Resident #2's care plan dated 1/29/16 documented the following: "Skin Integrity Needs ...Float heels-on pillows while in bed as tolerated by resident. Check placement each shift q (every shift) (Started January 6, 2016-continuing)."

Review of Resident #2's revised care plan dated 3/24/16 did not have "Float Heels" as an intervention for focus area, "Impaired skin integrity."

Resident #2's April 2016 and May 2016 TARS (treatment administration record) documented the following: "Float Heels while in bed every shift for Prevention." The TARS revealed blanks (no signatures) for the following dates and times:

4/8/16 day shift; 4/9/16 evening shift; 4/23/16 day and evening shift; and 4/24/16 evening shift.

Review of Resident #2's most recent Skin Risk Assessment dated 1/1/2016, coded resident #2 as a high risk for developing pressure ulcers.

On 5/5/16 at 8:45 a.m., LPN #6, the wound care nurse, checked Resident #2's heels with this surveyor. Resident #2's bilateral heels were observed to be blanchable upon touch. At 8:55 a.m., when asked if Resident #2 should have her heels floated, LPN #6 stated, "I am not sure. I would have to check her orders, but if not I will initiate heel boots." When LPN #6 was shown Resident #2's orders, she stated, "Well then yes they should be floated." When asked who was responsible for ensuring feet were floated, she stated, "The nurses." When asked who is

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responsible for signing off the TARS (Treatment Administration Record) she stated, "The nurses." When asked what blanks meant on the TARS she stated, "Either it wasn't done or they forgot to sign." LPN #6 was asked what she refers to before starting treatments for each resident. LPN #6 stated, "The TARS."

On 5/5/16 at 9:50 a.m., an interview was conducted with LPN #8. When asked who was responsible for ensuring heels are floated for residents with orders to float heels and pressure risk, she stated, "The nurses. The CNA's should float heels as well but it is ultimately up to the nurses to make sure it is being done." When asked where nurses document that this intervention is being put into place, she stated, "It should be on the TARS." When asked what blanks meant on the TARS she stated, "If it ' s not signed than it's not done." When asked if a resident has a physician order to float heels should this intervention be put into place, she stated, "Yes, heels should be floated if there is an order."

The facility Policy titled, "Pressure Sores" documents in part, the following: "It is the policy of this facility to ensure a patient who enters this facility without pressure sores does not develop sores unless the individual's clinical condition demonstrates that they were unavoidable; and a patient having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing ...The first step in prevention will be through identification of the patient at risk of developing pressure ulcers. This will be followed by implementation of appropriate individualized interventions and monitoring for the effectiveness

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F 314	Continued From page 35 of the interventions. According to Lippincott Manual of Nursing Practice, Eighth Edition, part 2, unit 1, section 9, special health problems of the older adult, page 187, "nursing and patient care considerations in prevention and healing of pressure ulcers; relieve the pressure by: reposition every two hours, using special devices to cushion specific areas such as the heels." On 5/5/16 at 12:17 p.m., ASM (Administrative Staff Member) #1, the administrator, was made aware of the above findings. No further information was presented prior to exit. (1) This information was obtained from the National Institutes of Health https://www.nlm.nih.gov/medlineplus/lupus.html (2) This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (3) This information was obtained from the National Institutes of Health https://www.nlm.nih.gov/medlineplus/pressuresores.html.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure that 1 of 29 residents in the survey sample was free of a Foley catheter without adequate indication and physician's order for its use.

Resident #1 was readmitted on 3/7/16 from the hospital with a Foley catheter present. The facility staff failed to obtain a physician's order for the continued use of the catheter. In addition the facility staff failed to assess the resident for the need of the Foley catheter and ascertain adequate indication for its use.

The findings include:

Resident #1 was admitted to the facility on 8/1/13 with the diagnoses of but not limited to epilepsy, below knee amputation, high blood pressure, respiratory failure, stroke, pressure sore, and feeding tube.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/16/16. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, eating, and dressing; extensive assistance for bed mobility and hygiene; and was coded as incontinent of bowel and bladder.

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1. The physician assessed Resident #1 for adequate indications and an order for use of a urinary catheter.
2. All residents with urinary catheters have the potential to be affected by this deficient practice.
   Audit completed of current residents with urinary catheters for appropriate justification and orders.
3. Nursing staff will be educated by the DON or designee on obtaining a physician's order and assessing and documenting adequate indications for the use of a urinary catheter.
4. Audits of physician's orders of residents with urinary catheters and documentation of adequate indications for the use of a urinary catheter will be conducted by the Unit manager or designee weekly for four weeks then randomly weekly for eight weeks. Results of audits will be taken to the QA committee for review and revision as needed monthly for two months.
5. Date of compliance: June 2, 2016.

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On 5/3/16 at 3:35 p.m., 5/4/16 at 9:32 a.m., and 5/5/16 at 9:40 a.m., observations were made of Resident #1. He was lying in bed, with a Foley* catheter bag hanging on the side of the bed frame.

A review of the clinical record failed to reveal an order for the use of the Foley catheter. In addition, there was no documented indication for its use.

Review of the clinical record revealed a readmission nursing note dated 3/7/16 that documented, "....16FR (french, a form of measurement) / 5cc (cubic centimeters) foley in place and clear yellow urine noted to tubing and present in bag...."

A nurse's note dated 3/8/16 documented, "....Resident has a urinary catheter. Foley catheter in place. Catheter is patent and draining..."

A nurse's note dated 3/17/16 documented, "....Foley patent...."

A nurse's note dated 4/4/16 documented, "...Foley care this shift without s/s (signs and symptoms) of discomfort..."

A nurse's note dated 4/7/16 documented, "...Resident has a urinary catheter. Foley catheter in place. Catheter is patent and draining..."

On 5/5/16 at 9:43 a.m., in an interview with LPN #10 (Licensed Practical Nurse) she stated that the presence of the Foley was present on

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readmission and should have been assessed to determine if it was needed and an order obtained to continue its use, if needed. When asked why the resident had one, she stated she thought it was for sacral wound protection. When asked what stage the wound was at the time of admission, she did not know.

A review of the clinical record revealed a wound assessment conducted 2 days after readmission, dated 3/9/16. This assessment documented the resident's wound was a Stage II.**

A review of the facility policy that was provided, which was an excerpt from Lippincott's Nursing Procedures, Sixth Edition, published 2013, documented, on page 377, "...Indwelling catheters are used most commonly to relieve bladder distention caused by urine retention and to allow continuous urine drainage when the urinary meatus is swollen from childbirth, surgery, or local trauma. Other indications for an indwelling catheter include urinary tract obstruction, (by a tumor or enlarged prostate), urine retention or infection from neurogenic bladder paralysis caused by spinal cord injury or disease, and any illness in which the patient's urine output must be monitored closely....Verify the order on the patient's medical record to determine if a catheter size or type has been specified..."

On 5/5/16 at 11:00 a.m., the Assistant Director of Nursing ADON, Administrative Staff #3) was made aware of the findings. She stated the catheter should not be used for a Stage II wound, and there should be a physician's order for it if a catheter is needed. At 3:43 p.m., the DON (Director of Nursing, Administrative Staff #2)

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stated there was no other information regarding the presence of the Foley at admission.

"Inserting a Straight or Indwelling Urinary Catheter. . .Procedure: 1. Verify the physician's orders and identify the client." Fundamentals of Nursing, 5th edition, Lippincott, p. 1104.

*According to Fundamentals of Nursing Lippincott Williams and Wilkins page 593.
"An indwelling urinary catheter also called a Foley catheter, provides the patient with continuous urine drainage. It is a latex or silicone tube which is inserted into the bladder and a small balloon is inflated at the catheter's distal end to prevent it from slipping out. A catheter is used for numerous reasons, but usually when there is a problem resulting in the inability to pass urine, such as in an obstruction or neurological (nerve, brain or spinal cord) disease or injury..."

**According to the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm

Stage II:
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Further description:
Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

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The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to implement interventions, supervision to ensure resident safety and a safe environment, to prevent a resident from injuring herself after she voiced a threat of self-harm for one of 29 residents in the survey sample, Resident #22.

A threat of self-harm was reported to facility staff (4/15/16 at approximately 3:10 p.m.) by the resident and the facility staff did not act on the threat. None of the following were done prior to Resident # 22 stabbing herself with a scissors on the afternoon of 4/15/16 at 4:45 p.m.

- Notification of supervisory staff, Administrator, Director of Nurses of Resident # 22's comment of self-harm,
- Notification of physician of Resident # 22's comment of self-harm,
- No assessment of the resident's environment for potential safety issues and removal of any items that could be a hazard,
- Monitoring/ supervision of Resident # 22 related to the self-harm comment

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1. Resident #22 is no longer in the facility.
2. All residents who express the intent to self-harm have the potential to be affected by this deficient practice.
3. Staff were educated by the Director of Nursing or designee on the need to immediately notify supervisory staff, the physician and responsible party of any resident's verbalization of intent to self-harm; the need to immediately assess the resident's environment for potential safety hazards and remove any items that could be a hazard; and the need to monitor /supervise the resident related to the self-harm comment.
4. For three months, audits will be conducted with each new occurrence by the Unit Manager or designee to assure that the process was implemented timely . Results of audits will be taken to the QA committee for review and revision as needed monthly for three months.
5. Date of completion: June 2, 2016.

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The findings include:

Resident # 22 was admitted to the facility on 11/20/15 with a recent readmission on 3/18/16 with diagnoses that included but were not limited to: anemia, atrial fibrillation, congestive heart failure, hypertension, gastroesophageal reflux disease, renal insufficiency, hyperlipidemia, thyroid disorder, depression, and diabetes.

The most recent MDS (minimum data set) assessment, a Significant Change Assessment, with an assessment reference date of 3/25/16, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one person for all of her activities of daily living. Review of the three previous MDS assessments for Section D Mood documented the following: an admission assessment with an ARD of 11/27/15 documented a Total Severity Score of 1; a quarterly assessment with an ARD of 2/8/16 documented a Total Severity Score of 4; and a Significant Change Assessment with an ARD of 3/25/16 documented a Total Severity Score* of 6. Review of the previous three MDS assessments for Section E Behavior documented the following: an admission assessment with an ARD of 11/27/15 documented Resident #22 had no behaviors; a quarterly assessment with an ARD of 2/8/16 documented no behaviors; and a Significant Change Assessment with an ARD of 3/25/16 documented no behaviors.

*Total Severity Score is a summary of the frequency scores that indicates the extent of

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potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists. CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) MDS 3.0 Manual page D-8.

Review of Resident # 22's clinical record revealed that she was being treated for depression with Sertraline*. This is used to treat depression, obsessive-compulsive disorder, bothersome thoughts that won't go away and ... including mood swings, irritability, bloating, and breast tenderness. Resident # 22 was under the care of a psychiatrist. Review of the psychiatric notes did reveal that Resident # 22's chief complaints were depression, insomnia, and anxiety. Further review of the psychiatric notes did not reveal any documentation of statements for self injurious behavior or thoughts.

*This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a697048.html -

During an interview on 5/5/16 at 9:40 a.m. with OSM (other staff member) #10, an assistant in the business office, OSM # 10 reported that on 4/15/16 at approximately 3:10 p.m. while he was conducting room rounds Resident # 22 reported to him that she was in a lot of pain. OSM # 10 stated the resident's pain was in both of her legs. OSM # 10 further stated that he told the resident that he would check with the nurse (about pain medication). OSM # 10 stated that resident # 22 threatened to harm herself, "She would have to

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find something to hurt herself if she could not be helped with the pain." OSM # 10 said he told the resident, "No, don't do that; let me talk to the nurse and see if they can get you something for the pain." OSM # 10 then stated he went to Resident # 22's nurse [LPN (licensed practical nurse) # 15] and told him that she was in pain. OSM # 10 stated he did not remember telling the nurse about the threat only about the pain but when he returned from rounds to hand in his papers for rounds he definitely told RN (registered nurse) # 3, MDS nurse, and OSM # 12, a social worker, about Resident # 22's pain and her threat to hurt herself. OSM # 10 stated that he told the nurse (LPN # 15) only about the pain; this was confirmed in another interview with OSM # 10 on 5/5/16 at 11:30 a.m.

During an interview on 5/5/16 at 10:23 a.m., with RN (registered nurse) # 3, the MDS coordinator, RN #3 related the events of 4/15/16 as she remembered them. RN #3 stated rounds are done at the beginning of the day and at the end of the day. It was about 3:30 p.m. and (Name of OSM # 12, the social worker) was in the room when (name of OSM # 10, staff member that the threat was reported to) was reporting his findings. OSM # 10 stated that (name of Resident # 22) was in a lot of pain in her legs and that she needed something for pain. He further stated the resident stated that if she could not get something she might hurt herself. OSM # 10 told her (RN # 3) that he told the nurse (LPN # 15) about (name of Resident # 22's) pain and the nurse stated the Resident had just had something for pain. He (OSM # 10) could only remember that he told the nurse (LPN# 15) that resident was requesting something for pain but not about the threat to hurt herself. RN # 3 stated OSM # 12 was present for

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this conversation. During another interview on 5/5/16 at 1:00 p.m. (concerning events of 4/15/16) with RN # 3, RN # 3 repeated that she knew about the threat and that OSM # 12 was in the room when OSM # 10 reported the threat. RN # 3 stated that others in the room, whom she could not identify, stated that the Unit Manager (RN #4) and the physician (ASM # 4) were in the Resident's room. RN # 3 stated OSM # 12, the social worker got up and left the room, although RN # 3 did not know where OSM # 12 was going and did not ask. RN # 3 stated, "I thought (name of OSM # 12) was going down to see her (Resident # 22) when she left the room." She (RN # 3) stated she thought everything was being addressed but did not go down there to make sure. When asked if she knew how Resident #22 got the scissors, she stated that she did not.

During an interview on 5/5/16 at 10:04 a.m. with OSM # 12, the social worker, OSM # 12 related what she remembered: When she (OSM # 12) got to the "stand down meeting" at 3:30 p.m. (on 4/15/16) (names of RN # 3 and OSM # 10) were in the room. OSM # 12 reported that she heard OSM # 10 was saying (name of Resident # 22) made a statement she (Resident # 22) wished she was dead because she was in so much pain. OSM # 12 understood OSM # 10 to say he had already notified nursing about the pain and she (OSM # 12) understood that nursing was down there (in the resident's room) assessing the Resident's pain. OSM # 12 also stated there was a distinction between the resident stating "I wish I was dead" and "I am going to find something to hurt myself" they are not the same. OSM #12 stated, "If the resident had said, 'I'm going to hurt myself, I would have acted immediately." When asked if she (OSM # 12) went down to see the

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resident OSM # 12 stated, "I did not physically go down and see the resident."

During an interview on 5/5/16 at 1:25 p.m. with OSM # 12, OSM # 12 again repeated that, "I wish I was dead was not a statement of self-harm."

Review of the clinical record revealed a "Social Services Note dated 4/16/16 at 15:23 (3:23 p.m.) (the day after the incident)." This note documented the SW (social worker - OSM # 12) was following up on Resident # 22 and if she (Resident # 22) intended to harm herself. There was no note prior to this note documenting that the social worker was monitoring the Resident for threats of self-harm.

During an interview on 5/5/16 at 9:55 a.m. with RN (registered nurse) # 4, the unit manager, on Resident # 22's unit, RN # 4 stated she was not aware of the Resident's threat. RN # 4 stated, she and ASM (administrative staff member) # 4, the physician, were doing rounds (at approximately 3:30 p.m. on 4/15/16) and were in the resident's room. Resident # 22 reported she had pain. RN # 4 stated she notified the charge nurse of the resident's pain. The physician was examining her. RN # 4 stated that Resident # 22 did not report that she (Resident # 22) might hurt herself.

An interview on 5/5/16 at 11:15 a.m. with LPN # 15 revealed the following: LPN # 15 only recalled she (Resident # 22) complained of mild pain and LPN # 15 medicated her with Tylenol* for that at about 2:40 p.m. LPN # 15 stated, "I do not recall anyone telling me that she had any pain or that she had threatened to hurt herself. I checked on the resident at approximately 3:20 p.m. and she

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was watching TV and had no complaints of pain at that time." LPN # 15 further stated the resident never mentioned hurting herself and no others told him she had made that threat. LPN # 15 stated if a threat had been made to him or reported to him, he (LPN # 15) "I would have been all over it."

A request was made for any facility incident report related to this incident. On 5/5/16 at 2:45 p.m. ASM # 3, the assistant director of nursing, stated that she had looked for an incident report and could not locate one. ASM # 3 stated, "It was not done."

During an interview on 5/5/16 at approximately 2:50 p.m. with ASM # 4, the physician, ASM # 4 stated, "No, I was not aware of any threat, she was on hospice and in a lot of pain. She (the resident) never indicated to me that she might hurt herself. No one came to (name of RN # 4) or I (ASM # 4) about a threat."

Review of the clinical record revealed the following documentation: "Nursing Note, 4/15/16 22:23 (10:23 p.m.) Note Text: @ (at) 1531 (3:30 p.m.) resident called for pain med and oxycodone** 5 mg was given to resident. CNA (certified nurse's assistant) notified writer @ 1645 (4:45 p.m.) that resident had stabbed herself with scissors. Writer noted scissors in residents left abdominal area with blood seeping from area. Writer then covered area with gauze. Writer left the room immediately and called for more help leaving two care givers to assist in monitoring resident while ADON (assistant director of nurses - ASM # 3), MD (Medical doctor - ASM # 4), Unit Manager (RN # 4) were called into the room immediately 911 were immediately notified @

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1647 (4:47 p.m.) resident asked for pain med (medication) and morphine 0.25 mg (milligram) was given. Vitals were obtained (bp - 123/68, p - 73, t - 98.8, r - 18). RP (responsible party) notified @ 1655 (4:55 p.m.), voicemail left and call was returned @ 1725 (5:25 p.m.) and @ 1653 (4:56 p.m.), At home care made aware. 911 arrived, resident was then transported to (name of local hospital). @ 2145 (9:45 p.m.), (name of local hospital) called back that resident was coming back. At this time, resident is not in the building yet." Note: bp - blood pressure, p - pulse, t - temperature, r - respirations.

Review of the physician note dated 4/15/16 did not evidence any documentation of self harm statements by the resident or assessment of self injury behaviors for Resident #22.

Review of the hospital record revealed the following documentation: "4/15/2016 17:57 (5:57 p.m.) EDT (emergency department trauma) ...History of Present Illness: The patient presents with major trauma. The onset was just prior to arrival. The course of symptoms is constant and worsening. Type of injury: puncture wound. The location where the incident occurred was at a nursing home. Location: abdomen. The character of symptoms is pain and bleeding. Associated symptoms: LLQ (lower left quadrant) abdominal pain, BLE (bilateral lower extremities) pain." "Medical Decision Making: Trauma team: Trauma criteria met, trauma team assembled, trauma surgeon present. Differential Diagnosis: Contusion, laceration."

CT (computed tomography): Abd (abdomen)/Pelvis (soft tissue) -- findings: Superficial penetrating wound left lower abdomen

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with no evidence of intraperitoneal bowel injury.

"Assessment/Plan: Patient stabbed herself in the abdomen and trauma removed the scissors on arrival....." The ED (emergency Department) record further documented the resident was evaluated by a psychiatrist and denied she intended to kill herslef and.. "They cleared the patient to go home."

Review of Resident # 22's care plan revealed documentation of a care plan for pain. That was initiated on 3/21/16. Further review revealed no documentation for care plans for behavior, mood, or depression.

Review of Resident # 22's clinical record failed to document evidence of the following after Resident # 22 made a threat of self-harm on 4/15/16 at approximately 3:10 p.m.:

- Notification of supervisory staff, Administrator, Director of Nurses of Resident # 22 comment of self-harm,
- Notification of physician of Resident # 22's comment of self-harm,
- No assessment of the resident's environment for potential safety issues and removal of any items that could be a hazard,
- Monitoring /supervision of Resident # 22 related to the self-harm comment

During an interview on 5/5/16 at 8:20 a.m. with CNA (certified nurse's assistant) # 5, CNA # 5 stated that if a resident expressed a threat of self-harm she (CNA # 5) would let the nurse know immediately, and if the nurse did not respond she would go up the chain of command.

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An interview was conducted on 5/5/16 at 8:30 a.m. with CNA # 10, CNA # 10 stated that she would report any threats a resident made to the nurse, and if the nurse did not respond she would go to the nursing supervisor, and if she got no response she would go higher to the Director of Nurses.

During an interview on 5/5/16 at approximately 8:40 a.m. with CNA # 11, CNA # 11 stated I would make sure that the resident's call bell was in place, lower the bed, and then I would go report the comment to the nurse. If the nurse did not respond I would go to the unit manager then the assistant director of nurses, then the Director of nurses and finally the administrator until there was a response.

Review of the facility policy: "Suicide Prevention Plan" documented the following: "POLICY: it is the policy of this facility to provide a guideline, safety measures and treatments to patients who present a suicide risk. Patients who are actively suicidal cannot be cared for at FACILITY. Staff observing potential suicidal statements and behaviors exhibited by patients will report to supervisory staff immediately and take measures to promote safety." Under "PROCEDURE: ...2. If a patient mentions suicidal ideation at any time, this is reported to the charge nurse, Director of Nursing, Social Worker and Physician to evaluate the threat. 3. All staff members are obligated to report suicidal statements or other indicators of possible ideation to their immediate supervisor. Supervisor to notify physician and psychologist. Assess the patient's environment and remove items or modify conditions to insure safety. Document observations and actions taken in the

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medical record. 4. If the patient is determined to be actively suicidal with the intent to harm themselves and the ability to do so, they will be transferred to an acute hospital or other appropriate higher level of care. 5. If the patient is actively suicidal, but with limited physical abilities to carry it out, can be persuaded to agree not to kill themselves or who is passively suicidal, a plan of care is developed with interdisciplinary coordination to reduce risk of self-harm and to restore feelings of well-being. 6. At any time a patient is deemed to be at risk of engaging in suicidal or self-injurious behavior, the patient's environment must be examined to remove items or modify conditions that could be used by the patient to harm themselves. This includes, but is not limited to: *Removal of sharp objects (e.g., scissors, knives, nail files). *Visitation may be limited. *Access to windows or other glass items that could be broken to produce a sharp edge may be restricted or require observation. *Removal of belts, power cords, ties, shoelaces. *Removal of plastic bags. * Access to areas where staff cannot see the resident, or that can be locked to prevent entry may be restricted. *Access to chemicals, solvents or medications may be further restricted. *Access to power wheelchair may be restricted. *Leaving the unit while unsupervised may be prohibited (If the patient insists on this while being monitored for SI (suicidal ideation), they should be considered at high risk, and referred to an appropriate acute care setting for evaluation). *The patient may be moved for increased observation and to minimize access to items that may be unknown to staff."

Review of the facility policy: "Nursing-Notification of Changes" documented the following: "POLICY: It is the policy of this facility to inform the patient,

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consult with the patient's physician and notify the patient's legal representative or an interested family member when there is an accident, a significant change in the patient's physical, mental or psychosocial status, a need to alter treatment significantly, a decision to transfer or discharge patient from the facility..." Under "PROCEDURE: ...2. Call the physician to advise and obtain orders..."

During an interview on 5/5/16 at 3:55 p.m. with ASM # 1, the Administrator, and ASM # 2 the Director of Nurses, in the presence of the survey team, this concern and the possibility of harm was reviewed. ASM # 1 and ASM # 2 were informed that they could have as much time as they needed to respond to this allegation. To which they responded that they did not have anything else.

Prior to exit no other information was provided for this concern.

After the survey on 5/6/16 at 1:57 p.m., the administrator, ASM #1 emailed the following letter from the physician, ASM # 4, to the state office:

"To whom it may concern,

Regarding the care of (name of Resident # 22):

I was with Unit Manager examining the above mentioned patient apparently 10 minutes after this patient indicated an expressed wording of wanting to end her pain/hurt herself. In no way did, ten minutes thereafter, in my evaluation of this patient was there any indication of any desire or expressed thought to believe patient would by

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any means, harm herself. No statement, no body language, no expression whatsoever. If there would have been any statement in the affirmative, in no way would there have been any alteration in the course of treatment than what was performed; to provide pain relief as a top priority.

Sincerely,

Name of Physician (ASM # 4)

Sent from my iPhone"

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.

Mood Disorders (especially depression) often are unrecognized or misdiagnosed in older adults. Symptoms of depression include poor cognitive performance, sleep problems, and lack of initiative - symptoms commonly seen in people with dementia .....Suicide is the most serious consequence of depression ....Many factors place an older adult at risk for depression, including recent bereavement, a change in environment, alcohol or substance abuse and chronic pain.

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Knowledge of these risk factors and careful assessment of older adults at risk allow the nurse to provide support, counseling, and appropriate and timely referral to a health provider for pharmacologic and psychotherapeutic interventions. Fundamentals of Nursing, 5th edition, Lippincott, Williams and Wilkins, page 316

* Tylenol ... Acetaminophen is used to relieve mild to moderate pain. https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=tylenol

** Oxycodone is used to relieve moderate to severe pain. <https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=oxycodone>

F 328 SS=D	COMPLAINT DEFICIENCY 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328	

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review it was determined that the facility staff failed to ensure a portable oxygen tank was stored in a safe manner for one of 29 residents, Resident #6; and on one of four nursing units, Winter unit.

1. A full portable oxygen tank was observed unsecured, leaning upright in the seat of the wheelchair in Resident # 6's room.

2. The facility staff failed to secure one portable oxygen tank in the Winter unit oxygen storage room.

The findings include:

1. A full portable oxygen tank was observed unsecured, leaning upright in the seat of the wheelchair in Resident # 6's room.

On 5/3/16 at 3:53 p.m. an observation of Resident # 6's room revealed a portable oxygen tank unsecured, leaning upright in the seat of the resident's wheelchair which was located at the foot of the resident's bed. Further observation revealed that the portable oxygen tank leaning in the seat unsecured in the resident's wheelchair could be seen from the hallway.

On 5/3/16 at 4:05 p.m. an observation of Resident # 6's room from the hallway revealed the portable oxygen tank leaning in the seat of the wheelchair unsecured.

F 328

1. The oxygen tank in the room of resident #6 was secured. The oxygen tank in the storage room was secured appropriately.
2. All residents have the potential to be affected by this deficient practice.
3. Staff were educated by the Director of Nursing or Designee on appropriate storage and safe handling of portable oxygen tanks.
4. Random audits of portable oxygen tanks in resident rooms and storage rooms will be conducted by the Unit Managers or designee daily five times weekly for four weeks , then randomly weekly for eight weeks for appropriate storage and handling. Results of audits will be taken to the QA committee for review and revision as needed monthly for two months.
5. Date of compliance: June 2, 2016.

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On 5/3/16 at 4:15 p.m. CNA (certified nursing assistant) # 7 was observed walking down the hallway. CNA # 7 stopped at the entrance of Resident # 6's room, looked in the room then preceded down the hallway.

On 5/3/16 at approximately 4:16 p.m. CNA # 6, staffing coordinator, entered Resident # 6's room, spoke with Resident # 6 then exited the room.

On 5/3/16 at approximately 4:18 p.m. observation of Resident # 6's room revealed the portable oxygen tank was unsecured, leaning upright in the seat of the resident's wheelchair which was located at the foot of the resident's bed.

On 5/3/16 at 4:30 p.m. LPN (licensed practical nurse) # 10 was asked to accompany this surveyor to Resident # 6's room. Upon entering Resident # 6's room, LPN # 10 was asked to read the gauge on the portable oxygen tank leaning in the seat of the wheelchair. When asked how much oxygen was in the portable tank, LPN # 10 stated, "It's full four thousand pounds." Observation of the gauge on the oxygen tank revealed that it indicated four thousand pounds per square inch (psi). LPN # 10 then immediately removed the portable oxygen tank from the seat of the wheelchair and hung it on the back of the wheelchair securing it.

On 5/3/16 at 4:55 p.m. an interview was conducted with LPN # 10. When asked how a full portable oxygen tank is to be secured on a resident's wheelchair, LPN # 10 stated, "It is hung on the back of the wheelchair." When asked about the portable oxygen tank in the wheelchair located in Resident # 6's room, LPN # 10 stated, "The oxygen tank was put in the wheelchair by

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hospice. They came and replaced the wheelchair for (Resident # 6). They took the portable oxygen tank off the old chair and placed it on the seat of the new chair. They should have secured the oxygen tank."

The facility document from the oxygen supplier regarding oxygen storage documented in part, "Process: (Name of company) follows the oxygen cylinder storage requirements according to the NFPA Standard 99 to ensure safety and compliance at all points of delivery...Regulations: Cylinders must be secured in racks or by chains..."

On 5/4/16 at 6:20 p.m., ASM # 1 (Administrative Staff Member), the administrator, and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was presented prior to exit.

2. The facility staff failed to secure one portable oxygen tank in the Winter unit oxygen storage room.

On 5/3/16 at 4:49 p.m., observation of the Winter unit oxygen storage room was conducted with LPN (licensed practical nurse) #7. One portable oxygen tank was observed lying horizontal and loosely wedged in between two secure vertical oxygen tanks. LPN #7 stated the oxygen tank was empty as evidenced by the lack of a white seal but the tank was supposed to be in the storage rack. LPN #7 stated the oxygen tank was smaller than the standard tanks and would rest on the floor if vertically placed in the standard size storage rack. When asked if there was a smaller rack to store that oxygen tank, LPN #7 stated that particular tank was used for residents who walk

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and was a special order tank that was left on the previous Friday. LPN #7 stated the facility was waiting for the oxygen delivery man to come to the facility to pick up the tank.

On 5/4/16 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility document from the oxygen supplier regarding oxygen storage documented in part, "Process: (Name of company) follows the oxygen cylinder storage requirements according to the NFPA Standard 99 to ensure safety and compliance at all points of delivery...Regulations: Cylinders must be secured in racks or by chains..."

No further information was presented prior to exit.

F 363 SS=E — 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED — F 363

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and facility document review, it was determined that facility staff failed to prepare food to meet resident's nutritive needs on two of four nursing units; Spring and Summer.

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1. The facility staff failed to ensure the menu for lunch on 5/4/16 was properly planned and followed for residents who were served corned beef, chicken nuggets, and tater tots on the Spring unit.

2. The facility staff failed to ensure the menu for lunch on 5/4/16 was properly planned and followed for residents who were served corned beef, chicken nuggets and tater tots on the Summer unit.

The findings include:

On 5/4/16 at 10:00 a.m., a group interview was conducted with five cognitively intact residents (all residents scored at least a 13 out of a possible 15 on the brief interview for mental status interview on their most recent minimum data set assessment). During the group meeting, all residents voiced concern regarding portion sizes of their meals.

On 5/4/16 at 12:10 p.m., observation of meal service on the Spring Unit was conducted. OSM (Other staff Member) #8 (dietary staff) was observed placing one slice of corn beef on one resident's plate and then two slices of corn beef on another resident's plate. OSM #8 did this several times during food service with the portion size of corn beef. OSM #8 was also observed serving 4 chicken nuggets (alternate meat) on one resident's plate and then 6 chicken nuggets on another resident's plate. OSM #8 was then observed using tongs to place tater tots (alternate side) on the resident's plate. There were inconsistencies in the amount of tater tots each resident was served.

1. No individual residents were identified.
2. All residents have the potential to be affected by this deficient practice.
3. Dietary staff were educated by the Dietitian or designee on correct portioning in compliance with dietitian-approved menus, to meet the nutritive needs of each resident.
4. Dietary manager or designee will complete audits 5 times a week at random meal times on each unit weekly for four weeks, then randomly for eight weeks. Results of audits will be taken to the QA committee for review and revision as needed monthly for two months.
5. Date of compliance: June 2, 2016.

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On 5/4/16 at 1: 45 p.m., an interview was conducted with OSM #8. When asked why some residents were given one piece of meat and others two she stated, "I don't know. I just to try to give the residents enough food. I estimate or guess to make sure they are not still hungry and are getting enough." OSM #8 had the same response when asked about the chicken nuggets and tater tots. When asked if she had a sheet that could tell her portion/serving sizes she stated, "Our dietary manager has a sheet and we will ask him if we are not sure."

On 5/4/16 at 2:12 p.m., an interview was conducted with OSM #1 (Dietary Manager) regarding portion sizes. OSM #1 stated that residents should have been given two to three ounces of potatoes or vegetables and between two to three ounces of meat for lunch. He stated these portions should be served for each meal daily. He stated he follows the facility's policy regarding portion sizes. He stated that every morning he has stand up meetings from 10 a.m. to 12 p.m. with dietary staff discussing portion sizes and the types of instruments used to serve food. OSM #1 stated two slices of the corn beef were supposed to equal three ounces of meat. OSM #1 stated he also told staff to give residents four chicken nuggets because four chicken nuggets equaled four ounces. OSM #1 further stated he told staff to use a four ounce scoop or ladle to serve tater tots. OSM #1 stated he was working on educating staff on portion sizes. He stated there was a high turnover and always new staff. He stated, "That is just the nature of the business." OSM #1 was asked to provide menus, guidelines and policies that documented how much food should have been served.

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On 5/5/16 at 9:48 a.m., OSM #1 presented a therapeutic menu spreadsheet for 5/4/16. The spreadsheet documented kielbasa as the meat that was supposed to be served for lunch. A line was drawn through kielbasa and "Corned Beef" was handwritten in pencil. The spreadsheet did not document how much corned beef was supposed to be served during lunch on 5/4/16. OSM #1 stated a new company had recently bought the facility and would not allow the facility to serve any tubular meat or sausage (due to choking hazards) so he had to substitute corned beef for kielbasa. OSM #1 presented a therapeutic menu spreadsheet for another meal during another week that documented two ounces of corned beef should be served. OSM #1 was asked to provide documentation that evidenced how many chicken nuggets should have been served. OSM #1 stated he obtained that information from the chicken nugget purchase invoice. OSM #1 was asked to also provide documentation that evidenced how many tater tots should have been served. OSM #1 stated he serves four ounces of tater tots. OSM #1 stated he follows the corporate guideline manual.

On 5/5/16 at 11:15 a.m., OSM #1 presented a purchase invoice for chicken nuggets that documented one chicken nugget equaled .5 to 1 ounce.

On 5/5/16 at 12:04 p.m., a phone interview was conducted with OSM #4, the dietician. She stated that she would guess about 4 chicken nuggets should be served. She stated that the exact portion should be documented on the therapeutic menu spreadsheet. OSM #4 was asked how

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many tater tots should have been served on 5/4/16 and stated staff should use a scoop and usually one half cup was served.

On 5/5/16 at 1:00 p.m., OSM #1 presented the alternate lunch menu for 5/4/16. The menu documented one chicken cacciatore and one half cup of buttered noodles should have been served. A line was drawn through chicken cacciatore and buttered noodles. "Chicken Nuggets 4 EA (each)" and "Tater tots 4 oz (ounce) scoop" was handwritten in pencil. OSM #1 also presented a therapeutic menu spreadsheet for dinner for another day that documented eight tater tots should have been served. OSM #1 stated the residents didn't like chicken cacciatore so chicken nuggets and tater tots were served on 5/4/16 as an alternate meal. OSM #1 stated the amount of chicken nuggets to be served was not documented on any of the therapeutic menu spreadsheets so he used four ounces. OSM #1 stated the chicken nuggets weighed one half to one ounce so three to four ounces was served. When asked how he knew how many chicken nuggets should be served, OSM #1 stated the protein on the menus ranged between two to four ounces for each meal so he decided to use the high end of the range and serve four ounces. OSM #1 was asked to present the therapeutic menu spreadsheets for all meals served on 5/4/16.

On 5/5/16 at 1:20 p.m., OSM #1 presented all therapeutic menu spreadsheets for the meals served on 5/4/16. OSM #1 stated he substitutes foods that residents like and "uses the higher end of ounces the best I can." OSM #1 was asked who approves his substitute meals and serving sizes. OSM #1 stated he talked to the corporate

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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registered dietician who had not viewed all of his changes but was aware he was making changes to the menus. OSM #1 stated the corporate dietician would print and approve the changes if they continued.

The food storage and food service policies presented, failed to document information regarding portion/serving sizes. No further information was provided prior to exit.

On 5/5/16 at 1 p.m., ASM (administrative staff member) #1 was made aware of the above concern. No further information was presented prior to exit.

2. The facility staff failed to ensure the menu for lunch on 5/4/16 was properly planned and followed for residents who were served corned beef, chicken nuggets and tater tots on the Summer unit.

On 5/4/16 at 10:00 a.m., a group interview was conducted with five cognitively intact residents (all residents scored at least a 13 out of a possible 15 on the brief interview for mental status interview on their most recent minimum data set assessment). During the group meeting, all residents voiced concern regarding portion sizes of their meals.

On 5/4/16 at 12:06 p.m., observation of meal service on the Summer unit was conducted. OSM #3 (a dietary aid) was observed placing one slice of corned beef on plates served to residents. OSM #3 was observed placing five chicken nuggets (alternate meat) on one plate served to a resident and placing six chicken nuggets on one plate served to a resident. OSM #3 was

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observed placing two handfuls of tater tots (alternate side dish) on one plate served to a resident.

On 5/4/16 at 1:15 p.m., an interview was conducted with OSM #3. OSM #3 was asked how she knew how much food to serve. OSM #3 stated she gives residents one slice of meat unless the cook says to give two slices. In regards to chicken nuggets, OSM #3 stated she just gives five or six nuggets because she is not told a specific amount. In regards to tater tots, OSM #3 stated she is told to give a handful.

On 5/4/16 at 1:25 p.m., OSM #3 was asked to weigh one slice of corned beef in the presence of OSM #1 (the dietary manager). One slice of corned beef weighed 1.75 ounces (confirmed by OSM #1). At this time, OSM #1asked OSM #3 how much corned beef was served; OSM #3 stated she served one piece.

On 5/4/16 at 2:12 p.m., an interview was conducted with OSM #1 regarding portion/serving sizes. OSM #1 stated three ounces of potatoes and vegetables, and two to three ounces of meat is served at each meal. OSM #1 stated he obtains this information from the guidelines in the facility policy. OSM #1 stated he has a stand up meeting with the dietary staff every day between 10:00 a.m. and 12:00 p.m. to explain serving sizes and what types of instruments have to be used to serve food. OSM #1 stated on this date, he told dietary staff three ounces of corned beef had to be served and three ounces equaled two slices. OSM #1 stated he also told staff to give residents four chicken nuggets because four chicken nuggets equaled four ounces. OSM #1 further stated he told staff to use a four ounce

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scoop or ladle to serve tater tots. At this time, OSM #1 was asked to provide menus, guidelines and policies that documented how much food should have been served.

On 5/4/16 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. Policies and guidelines regarding portion/serving sizes were requested.

On 5/5/16 at 9:48 a.m., OSM #1 presented a therapeutic menu spreadsheet for 5/4/16. The spreadsheet documented kielbasa as the meat that was supposed to be served for lunch. A line was drawn through kielbasa and "Corned Beef" was handwritten in pencil. The spreadsheet failed to document how much corned beef was supposed to be served during lunch on 5/4/16. OSM #1 stated a new company had recently bought the facility and would not allow the facility to serve any tubular meat so he had to substitute corned beef for kielbasa. OSM #1 presented a therapeutic menu spreadsheet for another meal during another week that documented two ounces of corned beef should be served. At this time, OSM #1 was made aware of the concern that one slice of corned beef was served, various amounts of chicken nuggets was served and two handfuls of tater tots was served on 5/4/16 during lunch on the Summer unit. OSM #1 stated he and his staff were nervous because they hadn't been around surveyors. OSM #1 was asked to provide the therapeutic menu spreadsheets that documented how many chicken nuggets and tater tots should have been served during lunch on 5/4/16. OSM #1 stated the chicken nuggets and tater tots were served as a substitute because the residents didn't like the previous alternate meal. OSM #1 stated he told dietary staff to serve four

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chicken nuggets because four chicken nuggets equaled four ounces. OSM #1 was asked to provide documentation that evidenced how many chicken nuggets should have been served. OSM #1 stated he obtained that information from the chicken nugget purchase invoice. OSM #1 was asked to also provide documentation that evidenced how many tater tots should have been served. OSM #1 stated he serves four ounces of tater tots. OSM #1 stated he follows the corporate guideline manual.

On 5/5/16 at 11:00 a.m. ASM #1, the administrator was made aware of the above findings. ASM #1 was made aware this surveyor requested and had not received therapeutic menu spreadsheets that documented how many chicken nuggets and tater tots should have been served during lunch on 5/4/16.

On 5/5/16 at 11:15 a.m., OSM #1 presented a purchase invoice for chicken nuggets that documented the weight of one chicken nugget was one half to one ounce per nugget.

On 5/5/16 at 12:05 p.m., a telephone interview was conducted with OSM #4 (the registered dietician). OSM #4 was asked how dietary staff knew portion/serving sizes for each food served. OSM #4 stated the amounts would be different depending on each meal and staff should be using the menus for that week. OSM #4 was asked how many chicken nuggets should have been served on 5/4/16 and stated she guessed four chicken nuggets but the therapeutic menu spreadsheet should document this information. OSM #4 was asked how many tater tots should have been served on 5/4/16 and stated staff should use a scoop and usually one half cup was

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F 363

served.

On 5/5/16 at 12:20 p.m., OSM #1 was asked to provide therapeutic menu spreadsheets that reflected required portion sizes for the meals served on 5/4/16.

On 5/5/16 at 12:50 p.m., ASM #1 was made aware this surveyor requested and had not received the therapeutic menu spreadsheets for chicken nuggets, tater tots and all meals served on 5/4/16.

On 5/5/16 at 1:00 p.m., OSM #1 presented the alternate lunch menu for 5/4/16. The menu documented one chicken cacciatore and one half cup of buttered noodles should have been served. A line was drawn through chicken cacciatore and buttered noodles. "Chicken Nuggets 4 EA (each)" and "Tater tots 4 oz (ounce) scoop" was handwritten in pencil. OSM #1 also presented a therapeutic menu spreadsheet for dinner for another day that documented eight tater tots should have been served. OSM #1 stated the residents didn't like chicken cacciatore so chicken nuggets and tater tots were served on 5/4/16 as an alternate meal. OSM #1 stated the amount of chicken nuggets to be served was not documented on any of the therapeutic menu spreadsheets so he used four ounces. OSM #1 stated the chicken nuggets weighed one half to one ounce so three to four ounces was served. When asked how he knew how many chicken nuggets should be served, OSM #1 stated the protein on the menus ranged between two to four ounces for each meal so he decided to use the high end of the range and serve four ounces. OSM #1 was asked to present the therapeutic menu spreadsheets for all

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meals served on 5/4/16.

On 5/5/16 at 1:10 p.m., ASM #1 was made aware of the above interview.

On 5/5/16 at 1:20 p.m., OSM #1 presented all therapeutic menu spreadsheets for the meals served on 5/4/16. OSM #1 stated he substitutes foods that residents like and "uses the higher end of ounces the best I can." OSM #1 was asked who approves his substitute meals and serving sizes. OSM #1 stated he talked to the corporate registered dietician who had not viewed all of his changes but was aware he was making changes to the menus. OSM #1 stated the corporate dietician would print and approve the changes if they continued.

The food storage and food service policies presented, failed to document information regarding portion/serving sizes. No further information was provided prior to exit.

F 364 SS=E 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP — F 364

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and facility document review it was determined that facility staff failed to serve food at a palatable temperature on three of four nursing

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units; Spring, Winter and Summer.

1. During food service observation on 5/4/16, facility staff failed to serve corn beef, chicken nuggets, and hash browns at a palatable temperature on the Spring Unit.

2. The facility staff failed to serve pureed meat and vegetables, potato tots, chicken nuggets and corned beef at a palatable temperature at lunch on 5/4/16 on the Winter Unit.

3. The facility staff failed to serve food that was warm enough to be palatable on 5/4/16 during lunch on the Summer Unit.

The findings include:

1. During food service observation on 5/4/16, facility staff failed to serve corned beef, chicken nuggets, and hash browns at a palatable temperature on the Spring Unit.

On 5/4/16 at 12:00 p.m. the food service observation was conducted on the Spring unit. The following holding temperatures were recorded by OSM (Other Staff Member) #8, the dietary aide at 12:05 p.m.:

Mashed potatoes: 167.5 degrees Fahrenheit
Cabbage: 187.2 F
Corned beef (regular texture): 159.4 F
Chicken nuggets: 167.6 F
Hash Browns: 167 degrees F
Mechanical Soft corned beef: 181 F
Puree cabbage: 166.6 F
Puree Corn Beef: 170 F

1. No individual residents were identified.
2. All residents have the potential to be affected by this deficient practice.
3. Dietary staff were educated by the Dietitian or designee on the proper methods and procedures for taking holding and serving temperatures.
4. Dietary manager or designee will randomly audit holding and serving temperatures on units 5 times a week for four weeks then randomly for eight weeks. Results of audits will be taken to the QA committee for review and revision as needed monthly for two months.
5. Date of compliance: June 2, 2016

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On 5/4/16 at 1:43 p.m., the last tray left the service line. A test tray was requested. OSM #8 plated each food item from the steam table. At 1:45 p.m. the following temperatures were recorded by OSM #8.

Mashed Potatoes: 145 F
Corned beef (Regular texture): 102.4 F
Chicken nuggets: 101 F
Hash Browns: 106 F
Mechanical soft corned beef: 140.2
Puree Cabbage: 147 F
Puree corned beef: 139 F

On 5/4/16 at 1:45 p.m., the plated food was tested by this surveyor. The chicken nuggets, corn beef and hash browns tasted cold.

On 5/4/16 at 1:47 p.m., an interview was conducted with OSM #8, the dietary aide. She stated that she was not sure why the temperatures dropped so low. OSM #8 did not have a chance to taste the food as her dessert trays were knocked onto the floor by another staff member.

On 5/4/16 at 2:55 p.m., an interview was conducted with OSM #1, the dietary manager. He stated that in his opinion, palatability temperatures for hot foods should be around 110 degrees Fahrenheit. He stated that food should be warm not stoned cold. OSM #1 also stated that everyone has different preferences to how warm they like their food. He stated something may be wrong with the steam tables if the food is not keeping its temperature. OSM #1 stated that he was going to check out the steam tables.

The facility policy did not address palatability

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temperature of foods.

On 5/4/16 at 6:25 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.

2. The facility staff failed to serve pureed meat and vegetables, potato tots, chicken nuggets and corned beef at a palatable temperature at lunch on 5/4/16 on the Winter Unit.

A test tray was obtained on the Winter Unit during the lunch meal on 5/4/16. The food cart arrived on the Winter Unit kitchen from the main kitchen at 12:02 p.m. OSM (other staff member) #2, the dietary server, took the holding temperatures of three items at 12:06 p.m. The temperatures of these items were as follows (temperatures in degrees Fahrenheit): mashed potatoes - 179; cabbage - 191; corned beef - 174. Service of resident meals began at 12:10 p.m. At 12:20 p.m., OSM #1, the dietary manager, arrived in the Winter Unit kitchen. At 12:35 p.m., a test tray was requested from OSM #2. OSM #1 took the temperatures of the following foods (temperatures in degrees Fahrenheit): pureed meat - 121; pureed cabbage - 120; potato tots - 127; corned beef - 122. Each of these foods was tested for temperature palatability. None of these foods tasted hot or very warm. OSM #1 was asked to taste each of these foods and to describe the temperatures in terms of being a "hot meal served to the residents." He stated that the pureed vegetables "could be a little hotter," that the potato tots "need to be hotter" and that the corned beef was "not hot."

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On 5/4/16 at 2:10 p.m., OSM #1 was interviewed about the food temperatures as described above. He stated: "We have so many new people, and it is a process to get them all trained. He also stated: "Part of what we are doing in the kitchen is getting people to be consistent and to follow through." He stated that before the warm carts leave the main kitchen for delivery to the units, the cook takes the temperatures and loads the carts. The carts are dispersed to the different units. He stated that when the carts arrive on the units, the food temperatures should be taken again. When asked specifically about temperature palatability for a hot meal, he stated that as long as the food is above 110, it should be "okay." He stated that in a restaurant, customers are not served meals that are piping hot. He stated: "The food should be warm. Just not stone cold." OSM #1 was asked to provide policies regarding temperature palatability of hot foods.

On 5/5/16 at 6:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were informed of these concerns. Policies regarding temperature palatability for hot foods were again requested.

No further information was provided prior to exit.
3. The facility staff failed to serve food that was warm enough to be palatable on 5/4/16 during lunch on the Summer unit.

On 5/4/16 at 10:00 a.m., a group interview was conducted with five cognitively intact residents (all residents scored at least a 13 out of a possible 15 on the brief interview for mental status interview on their most recent minimum data set assessment). During the group meeting, all

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residents voiced concern regarding temperatures of the food. The residents stated the food that was supposed to be warm was cold and the food that was supposed to cold was warm.

On 5/4/16 at 12:06 p.m., observation of meal service on the Summer unit was conducted. The holding temperatures of the food were taken by OSM (other staff member) #3 (a dietary aid) prior to the food being plated. The holding temperatures were:

Corned beef- 165.4 (degrees Fahrenheit)
Mashed potatoes- 172.3
Cabbage- 182.2
Pureed cabbage- 158.5
Mechanical soft (chopped) corned beef- 176.3
Pureed corned beef- 161.2
Chicken nuggets- 123.4
Tater tots- 182
Coleslaw- 46.1

After the holding temperatures were taken, plates were prepared and residents were served. At 1:03 p.m., as the last plate was being served, a test tray was prepared by OSM #3. The temperatures of the food on the test tray were taken and the food was sampled by this surveyor and OSM #3. The temperatures at this time were:

Corned beef- 119
Mashed potatoes- 131.6
Cabbage- 128.9
Pureed cabbage- 120.1
Mechanical soft corned beef- 124.4
Pureed corned beef- 120.2
Chicken nuggets- 115
Tater tots- 119.4

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Coleslaw- 57

OSM #3 tasted the tater tots and stated, "They are almost cold; kind of." OSM #3 tasted the corned beef and stated it was, "not that hot." OSM #3 tasted a chicken nugget and stated it was, "not really hot." OSM #3 tasted the pureed cabbage and stated it was, "Not hot." This surveyor agreed the tater tots, corned beef, chicken nuggets and pureed cabbage was not warm.

On 5/4/16 at 2:12 p.m., an interview was conducted with OSM #1 (the dietary manager). OSM #1 stated to him, food temperatures should be 110 degrees or higher (when eaten). OSM #1 stated the food should be warm and not stone cold. OSM #1 stated he had been present on another unit during lunch service that day and the food on the last try served ranged between 115 to 125 degrees. At this time, OSM #1 was made aware that residents had voiced concern regarding food temperatures and of the findings documented above. A policy regarding food palatability was requested.

On 5/4/16 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings.

On 5/5/16 at 9:48 a.m., OSM #3 stated he talked to the corporate registered dietician and the facility did not have a policy regarding food palatability. OSM #3 stated determining food palatability was based on responses from residents and changes were made if the residents were unhappy.

No further information was presented prior to exit.

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and facility document review it was determined that the facility staff failed to store, prepare, and serve food in a sanitary manner in the main kitchen and on two of four nursing units; Winter and Summer.

1) Facility staff failed to dispose a container full of chipped beef gravy that had a use by date of 1/16/16 in one of one reach-in refrigerators.

2) The facility staff failed to obtain the holding temperatures of food prior to serving it to residents at lunch on 5/4/16 on the Winter Unit.

3) The facility staff failed to serve food that was held at proper temperatures on the Summer unit. The coleslaw was held at a temperature of 46.1 degrees Fahrenheit and the chicken nuggets were held at a temperature of 123.4 degrees Fahrenheit (the chicken nuggets were reheated in the microwave as they were plated; however, the temperature was not taken afterward).

1. No individual residents were identified.
2. All residents have the potential to be affected by this deficient practice.
3. Dietary staff were educated by the Dietitian or designee on the proper use of thermometers to assure proper holding/serving temperatures are maintained; sanitary storage and disposal of food.
4. Dietary manager or designee will complete audits five times a week for four weeks at random meal times on each unit. Holding/Serving temperatures will be recorded to assure that proper temperatures and proper storage, and disposal is maintained. Audits of food storage areas in the main kitchen and serving areas on the units will be completed by the Dietary Manager or designee five times weekly for four weeks. Results of audits will be taken to the QA committee for review and revision monthly for two months.
5. Date of compliance: June 2, 2016.

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The findings include:

1) Facility staff failed to dispose a container full of chipped beef gravy that had a use by date of 1/16/16 in one of one reach-in refrigerators.

On 5/3/16 at 12:15 p.m., inspection of the kitchen was conducted. At 12: 30 p.m. a container full of chipped beef gravy was observed in one of one reach in refrigerators. The use by date on top of the lid documented the following "1/16/16."

On 5/3/16 at 12:30 p.m. an interview was conducted with OSM (Other Staff Member) #1, the dietary manager. When asked if the chipped beef gravy was expired he stated, "I am not sure. The date on the lid may have been for another food item. Also sometimes the marker doesn't write properly on the lid. I think we just had this item in April. It is supposed to say 4/16/16. It was marked wrong." OSM #1 then took the chipped beef gravy out of the refrigerator and placed it near the sink. When asked how often dietary staff clean out the refrigerator he stated, "We clean out everyday." When asked if the chipped beef gravy was still expired if the date was supposed to be 4/16/16 he stated, "Yes."

Review of the Food Storage guidelines documents the following: "Meat Leftovers: Gravy and Meat: Refrigerator 37 to 40 degrees Fahrenheit 1-2 days; Freezer 0 degrees 2-3 months."

Review of the county health department report dated 3/7/15 documented in part, the following: "...Recommended providing in service training to staff on cooling methods and legibly marking dates on containers."

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On 5/4/16 at 10:45 a.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

2) The facility staff failed to obtain the holding temperatures of food prior to serving it to residents at lunch on 5/4/16 on the Winter Unit.

Observation was made of the lunch tray line service on the Winter Unit 5/4/16. The food cart arrived on the Winter Unit kitchen from the main kitchen at 12:02 p.m. OSM (other staff member) #2, the dietary server, took the holding temperatures of only three items at 12:06 p.m. The temperatures of these items were as follows (temperatures in degrees Fahrenheit): mashed potatoes - 179; cabbage - 191; corned beef - 174. Service of resident meals began at 12:10 p.m. In addition to the three items listed above, residents were also served chicken nuggets, pureed meat, pureed vegetables and potato tots from the tray line steam tables. At 12:20 p.m., OSM #1, the dietary manager, arrived in the Winter Unit kitchen.

On 5/4/16 at 12:45 p.m., OSM #2 was interviewed regarding the taking of temperatures prior to serving food from the steam table tray line. She stated: "I take the temps and record them in the book." When asked why she only took the temperatures of three foods, she stated: "That's what we do." When asked to show the surveyor the temperature log book, OSM #2 presented the surveyor with a binder. The binder

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contained evidence of food temperatures taken for the past seven days. For each of the meals (breakfast, lunch, and dinner) for the past seven days, only three foods and their temperatures were listed.

On 5/4/16 at 12:50 p.m., OSM #1 was informed of these concerns. He stated: "The temperatures of all the foods should be taken." He stated that his staff were nervous and made unusual mistakes because the surveyors were observing. OSM #1 was asked to look at the temperature logs for the Winter Unit with the surveyor. When shown evidence that the staff had been taking temperatures of only three foods items for all meals for the past seven days, OSM #1 made no comment.

On 5/4/16 at 2:10 p.m., OSM #1 was interviewed about the food temperatures as described above. He stated: "We have so many new people, and it is a process to get them all trained. He also stated: "Part of what we are doing in the kitchen is getting people to be consistent and to follow through." He stated that before the warm carts leave the main kitchen for delivery to the units, the cook takes the temperatures and loads the carts. The carts are dispersed to the different units. He stated that when the carts arrive on the units, the food temperatures of all foods should be taken again.

On 5/5/16 at 6:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were informed of these concerns. Policies regarding temperature palatability for hot foods were again requested.

No further information was provided prior to exit.

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3. The facility staff failed to serve food that was held at proper temperatures on the Summer unit. The coleslaw was held at a temperature of 46.1 degrees Fahrenheit and the chicken nuggets were held at a temperature of 123.4 degrees Fahrenheit (the chicken nuggets were reheated in the microwave as they were plated; however, the temperature was not taken afterward).

On 5/4/16 at 10:00 a.m., a group interview was conducted with five cognitively intact residents (all residents scored at least a 13 out of a possible 15 on the brief interview for mental status interview on their most recent minimum data set assessment). During the group meeting, all residents voiced concern regarding temperatures of the food. The residents stated the food that was supposed to be warm was cold and the food that was supposed to cold was warm.

On 5/4/16 at 12:06 p.m., observation of meal service on the Summer unit was conducted. The holding temperatures of the food were taken by OSM (other staff member) #3 (a dietary aid) prior to the food being plated and served. The coleslaw was in a container on the counter and the holding temperature was 46.1 degrees Fahrenheit. The chicken nuggets were in the steam table and the holding temperature was 123.4 degrees Fahrenheit. Each time chicken nuggets were plated OSM #3 heated the chicken nuggets in the microwave but failed to take the temperature of the chicken nuggets before they were served.

On 5/4/16 at 1:15 p.m., an interview was conducted with OSM #3. OSM #3 stated holding temperatures should be at least 140 degrees for

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hot food and about 40 degrees for cold food. At this time, this surveyor stated the chicken nuggets were not at least 140 degrees. OSM #3 stated that's why she warmed the chicken nuggets in the microwave. OSM #3 stated she heated the chicken nuggets for 45 seconds and they were sizzling; however, OSM #3 acknowledged she didn't take the temperature of the chicken nuggets after she heated them in the microwave and stated she didn't know the exact temperature of the chicken nuggets after doing so. At this time, this surveyor stated the temperature of the coleslaw was above 40 degrees. OSM #3 stated normally she puts the container of coleslaw in ice but she was "running behind and got side tracked."

On 5/4/16 at 2:12 p.m., an interview was conducted with OSM #1 (the dietary manager). OSM #1 stated food temperatures are taken before the food carts leave the main kitchen. OSM #1 stated all of the food temperatures were above 185 degrees before the food was taken out of the kitchen for lunch that day. OSM #1 stated the food is taken to the units, installed into the steam tables and the food temperatures are taken again. OSM #1 stated all hot food that is below 135 degrees should be reheated. OSM #1 stated all cold food that is above 42 degrees should be disposed of. OSM #1 was made aware of the above findings.

On 5/4/16 at 6:25 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings.

The facility policy titled, "Food Service Hygiene" documented in part, "6. Delivery: a. Food is maintained at acceptable temperatures during

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F 371	Continued From page 80 service: Hot foods- 140 F (Fahrenheit) and above Cold foods- 41 F and below..." No further information was presented prior to exit.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure medications were available for two of 29 residents in the survey sample; Resident #2, and #11.	F 425		

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1. For Resident #2, facility staff failed to ensure medications were available upon admission for dates 1/1/16 and 1/2/16.

2. a. The facility staff failed to ensure the medication clonazepam was available for administration to Resident #11 three times on 3/12/16 and three times on 3/13/16.

b. The facility staff failed to ensure the medication pramipexole dihydrochloride was available for administration to Resident #11 once on 3/28/16.

The findings include:

Resident #2 was admitted to the facility on 1/1/16 with diagnoses that included but were not limited to high blood pressure, type two diabetes mellitus, major depressive disorder, anxiety disorder, atrial fibrillation, colon cancer and lupus (an autoimmune disorder that attacks healthy tissues and cells affecting the joints, skin, blood vessels and organs (1)).

Resident #2's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/9/16. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily life decisions scoring 8 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #2 was coded as requiring extensive assistance with transfers, dressing, toileting, and bathing; and independent with meals.

Review of Resident #2's clinical record revealed that Resident #2 arrived to the facility on 1/1/2016

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1. Medications for Residents #2 and #11 were reviewed and are available. The physician notified of medications not given for Residents.
2. All residents receiving medication have the potential to be affected by this deficient practice.
3. Nursing staff were educated by the Consultant Pharmacist and Designee on procedures to be followed to obtain medications in a timely manner, including pharmacy run times, contents of stat and emergency boxes, notification of on-call pharmacist and availability through the back-up pharmacy, and notification of physician if medications are unavailable.
4. Unit Managers or designee will audit MARS and documentation five times weekly for four weeks, then randomly weekly for eight weeks to assure that medication was received timely and administered as ordered. Results of audits will be taken to the QA committee for review and revision as needed monthly for two months.
5. Date of compliance: June 2, 2016.

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at 2:45 p.m.

Review of Resident #2's POS (Physician Order Sheet) for January 2016 through May 2016 documented the following orders:
"Bimatoprost Solution 0.01 % Instill 1 drop in both eyes in the evening for GLAUCOMA" (Used for the management of glaucoma (2)).
"Mirabegron ER (extended release) Tablet 24 HR (hour) Give 50 mg (milligrams) by mouth one time a day for HTN (high blood pressure)" (Used to treat overactive bladder (3) (a condition in which the bladder muscles contract uncontrollably and cause frequent urination, urgent need to urinate, and inability to control urination).
"PerserVision/Lutein (Multiple Vitamins-Minerals) Give 1 capsule by mouth two times a day for SUPPLEMENT" (Supplement to promote eye heath (4)).
"Azopt Suspension 1 % (Brimonidine Tablet) Instill 1 drop in both eyes two times a day for GLAUCOMA" (Used for the management of glaucoma (5)).
"Alphagan P Solution (Brimonidine Tartate) Instill 1 drop in both eyes two times a day for GLAUCOMA" (Used for the management of glaucoma (6)).
"Hydrocodone-Acetaminophen Tablet 7.5 mg -325 MG Give 1 tablet by mouth three times a day for PAIN" (Opioid analgesic used to decrease severity of moderate pain (7)).
Review of Resident #2's January 2016 MARS (Medication Administration Record) revealed Resident #2 was not given scheduled medications on 1/1/2016 and 1/2/16. The following medications were documented as "Not Done" on the January 2016 MARS:
- Bimatoprost 1 gtt(s) (drops) Ophthalmic (eye) Solution q.d. (every day) on 1/1/16 and 1/2/16 at

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7:00 p.m.
- Mirabegron ER (extended release) 25 mg (milligrams) Oral Tablet on 1/2/16 at 9:00 a.m.
- PreserVision/Lutein (ADREDS [Age-Related Eye Disease Study]) 1 Capsule Oral Capsule b.i.d. (twice a day) on 1/2/16 at 8:00 a.m. and 4:00 p.m.
- Azopt 1 gtt(s) Ophthalmic Solution b.i.d. on 1/2/16 at 8:00 a.m. and 4:00 p.m.
- Alphagan 1gtt(s) Opthalimc Solution b.i.d. on 1/2/16 at 8:00 a.m. and 4:00 p.m.
- Hydrocodone-Acetaminophen 7.5 mg-325 mg tablet: 1 Tablet Oral Tablet t.i.d (three times a day) on 1/1/16 at 10:00 p.m., 1/2/16 at 8:00 a.m., and 2:00 p.m.

Review of the emergency STAT (immediately) box list revealed that the above medications were not in the STAT box.

Review of the clinical record revealed a nurse's note dated 1/1/16 at 4:48 p.m. that documented the following: "Hard scripts received for Alprazolam (Xanax [antianxiety medication (8)]), Ceftin (antibiotic (9)), and Norco (Hydrocodone-Acetaminophen (10)). Per (name of doctor), orders followed from (Name of hospital) discharge summary and medications reconciled."

The next nurse's note dated 1/2/16 at 7:08 p.m., documented the following: "Late entry for 4:30. (Name of pharmacy), called in regards to medications, message left for on-call pharmacist, waiting return phone call."

No further nursing notes could be found regarding Resident #2's medications.

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Review of the pharmacy delivery manifest revealed that Resident #2's above medications arrived to the facility on 1/3/16 at 1:50 A.M.

On 5/5/16 at 8:40 a.m., an interview was conducted with RN (Registered Nurse) #1, regarding the process for ensuring medications are available for new admissions. RN #1 stated, "The resident will come into the facility with a list of medications from the hospital; a hospital discharge summary." She stated that these orders are transcribed onto the facility's POS (Physician order Sheet) and faxed to pharmacy. She stated the orders are reviewed with the physician before they are faxed to pharmacy. RN #1 was asked the process followed if medications are not available at the scheduled time. She stated, "Nursing would contact the pharmacy to let them know that the medications are not available. We would also check the STAT box to see if any medications are in there. If medications are not in the STAT box we would ask pharmacy to bring the medications on their next run." When asked if she would notify anyone if the medications were still not available she stated, "Yes the physician. He usually says give once medication available." She stated that the conversation with the MD (medical doctor) should be documented in the nurse's notes.

On 5/5/16 at 9:40 a.m., an interview was conducted with LPN #8, the nurse who wrote the note on 1/2/16 at 7:08 p.m. She stated that when a resident arrives to the facility nursing would fax orders to pharmacy and have them send it STAT (Immediately). She stated that if medications are still not available nursing would notify the physician. When asked if she could recollect the events on 1/1/16 and 1/2/16 for Resident #2 she

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stated, "That is my note but I am not sure why I got involved that night. I may have been the supervisor that night."

On 5/5/16 at 11: 50 a.m., an interview was conducted with RN #2 (admission nurse), the nurse who admitted Resident #2. When asked the admission process she stated, "I usually get the discharge summary before the resident is admitted to the facility. That way the medications are available. The discharge summary is then faxed to the pharmacy. RN #2 was asked what process is followed if medications are not delivered from the pharmacy in a timely manner. She stated, "The nurse would call pharmacy again to see if they can bring the medication up on the next run." RN #2 stated that she only faxes the admission orders and the floor nurses follow up on the medications from pharmacy. She stated, "I think the cut off time to order medications is 6 p.m. on Friday because the pharmacy closes for the weekend." When asked how residents receive medications if the pharmacy closes she stated, "I'm not sure. I don't usually work those times." When asked how weekend admissions receive medications she stated, "I don't work weekends. There might be after hour numbers."

The floor nurse who worked 1/1/16 could not be reached for an interview.

On 5/5/16 at 12:05 p.m. an interview was conducted with LPN # 9. She stated on weekends the facility will get admissions. She also stated there is an on-call pharmacist for the weekend to contact if medications are needed. She stated the facility also uses a backup pharmacy if medications are needed immediately.

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On 5/5/16 at approximately 12:17 p.m., ASM (administrative staff member) #3 stated the facility has an on-call pharmacist and backup pharmacy.

On 5/5/16 at approximately 1 p.m. an interview was conducted with OSM (Other Staff Member) #9, the pharmacist. He stated Resident #2's medications were faxed to the pharmacy on 1/1/16 at 5:00 p.m. He stated a pharmacist is on-call for the company at 6:00 p.m. He stated the on-call pharmacist handles orders that are called in after hours. OSM #9 stated if the facility does not order medications STAT then the back-up pharmacy is not contacted to deliver medications immediately. He stated he had no record of the facility calling in Resident #2's medications STAT. He stated because of this, the medications were filled on January 2nd and brought to the facility on January 3rd from their main pharmacy in North Carolina.

Facility Policy titled, "Pharmacy Hours" documents in part, the following: "Policy: A schedule of pharmacy hours is established and posted in a visible area in the facility...A. New Admission Cut off time Monday through Friday 2nd run 6:00 pm...Saturday New Admission cut off time 1:00 p.m...B. After hours, the phone will roll over to an on-call pharmacist who is available anytime outside of normal business hours."

Facility Policy titled, "Emergency Pharmacy Service" documents in part, the following: "Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply, through a back-up

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pharmacy or from (name of pharmacy) consultant pharmacy. (Name of pharmacy) consultant pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances, products for infusion in compliance with applicable state regulations."

On 5/5/16 at 12:30 p.m., ASM #3 (Administrative Staff Member), the ADON (Assistant Director of Nursing) was made aware of the above findings. No further information was presented prior to exit.

(1) This information was obtained from the National Institutes of Health https://www.nlm.nih.gov/medlineplus/lupus.html
(2) This information was obtained from Davis's Drug Guide for Nurses p.1355.
(3) This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a612038.html.
(4) This information was obtained from The National Institutes of Health. https://nei.nih.gov/amd/summary.
(5) This information was obtained from Davis's Drug Guide for Nurses p.1352.
(6) This information was obtained from Davis's Drug Guide for Nurses p.1357.
(7) This information was obtained from Davis's Drug Guide for Nurses p.637.
(8)This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a684001.html
(9)This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601206.html
(10) This information was obtained from The

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National Institutes of Health.
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a601006.html

2. a. The facility staff failed to ensure the medication clonazepam (used to control seizures and anxiety (1)) was available for administration to Resident #11 three times on 3/12/16 and three times on 3/13/16.

Resident #11 was admitted to the facility on 6/3/13. Resident #11's diagnoses included but were not limited to: dementia, heart failure and constipation. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/29/16, coded the resident's cognition as being moderately impaired.

Review of Resident #11's clinical record revealed a physician's order entered into the computer system on 12/4/15 for clonazepam 0.25 mg (milligrams) three times a day. Review of Resident #11's March 2016 eMAR (electronic medication administration record) revealed the clonazepam was not administered to Resident #11 on 3/12/16 at 9:00 a.m., 1:00 p.m. and 5:00 p.m. and on 3/13/16 at 9:00 a.m., 1:00 p.m. and 5:00 p.m.

A nurse's note dated 3/12/16 at 11:35 a.m. documented, "eMAR- Medication Administration Note- Note Text: Not available."

A nurse's note dated 3/12/16 at 1:31 p.m. documented, "eMAR- Medication Administration Note- Note Text: Not available."

A nurse's note dated 3/12/16 at 5:58 p.m.

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documented, "eMAR- Medication Administration Note- Note Text: Med (Medication) on order from pharmacy."

A nurse's note dated 3/13/16 at 9:09 a.m. documented, "eMAR- Medication Administration Note- Note Text: Not available."

A nurse's note dated 3/13/16 at 2:40 p.m. documented, "eMAR- Medication Administration Note- Note Text: Not available."

A nurse's note dated 3/13/16 at 6:05 p.m. documented, "eMAR- Medication Administration Note- Note Text: Med not available. Awaiting refill script from Physician."

Resident #11's comprehensive care plan documented, "PSYCHOACTIVE USAGE-ANTIANXIETY- Encourage to verbalize feelings, Medication as ordered, Monitor adjustment to placement (December 7, 2015). Diagnosis: ANXIETY DISORDER, UNSPECIFIED...Intervention: Medication as ordered..."

On 5/5/16 at 7:30 a.m., an interview was conducted with LPN (licensed practical nurse) #9 regarding the facility process for ensuring medication availability. LPN #9 stated she tries to call the medication in to the pharmacy ahead of time (before the medication runs out). LPN #9 stated the medication card containing the pills tells staff if more medication remains on the prescription. LPN #9 stated she also checks the bottom of the medication cart because extra medications are stored there. LPN #9 stated the facility also has a STAT medication box as a backup in case a resident runs out of medication.

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On 5/5/16 at 8:30 a.m., an interview was conducted with RN (registered nurse) #1 (the nurse responsible for administering Resident #11's clonazepam on 3/12/16 at 9:00 a.m. and 1:00 p.m. and on 3/13/16 at 9:00 a.m. and 1:00 p.m.) regarding the facility process for ensuring medication availability. RN #1 stated the cards containing the medications had an order sticker. RN #1 stated staff should remove the sticker from the card, place the sticker on the pharmacy refill order sheet and fax the refill order sheet to the pharmacy when five pills remain. RN #1 was asked the facility process for ensuring controlled substance medication availability. RN #1 stated nurses write a note to the physician requesting another prescription when five to six pills remain. RN #1 stated the prescription is faxed to the pharmacy after it is obtained from the physician. At this time, RN #1 was shown Resident #11's March 2016 eMAR and RN #1's nurse's notes dated 3/12/16 and 3/13/16. RN #1 was asked why Resident #11 wasn't administered clonazepam on these dates. RN #1 stated 3/12/16 and 3/13/16 was a weekend and the night shift nurse had noticed Resident #11's supply of clonazepam was getting low. RN #1 stated the night shift nurse said she was going to write a note for the physician but she (RN #1) didn't know what had happened. RN #1 stated she went to the medication STAT (immediately) box but the box didn't contain clonazepam. RN #1 was asked if she called the physician and stated, "No."

Review of the facility STAT medication box list revealed the box did not contain clonazepam.

The facility policy titled, "Medication Ordering and Receiving From Pharmacy" documented in part,

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"2. Medications refills are written on a medication order form/ordered by peeling the refill sticker portion of the label and placing it on the reorder sheet provided by the pharmacy for that purpose and ordered as follows: a. Quantities of medications sent from the pharmacy may vary in accordance with payer status, insurance plan, or law. Reorder medication five days in advance of need, as indicated by the reorder sticker, to assure an adequate supply is on hand..."

On 5/5/16 at 11:20 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

(1) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html

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b. The facility staff failed to ensure the medication pramipexole dihydrochloride (used to treat restless leg syndrome (1)) was available for administration to Resident #11 once on 3/28/16.

Review of Resident #11's clinical record revealed a physician's order entered into the computer system on 12/17/14 for pramipexole dihydrochloride 0.25 mg (milligrams) at bedtime. Review of Resident #11's March 2016 eMAR (electronic medication administration record) revealed the medication was not administered to Resident #11 on 3/28/16.

A nurse's note dated 3/28/16 documented,

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"eMAR- Medication Administration Note- Note Text: None in cart, on order from pharmacy."

Resident #11's comprehensive care plan documented, "PAIN/COMFORT NEEDS- AEB (as evidenced by) C/O (complaints of) pain, AEB use of pain meds (medications), Medication as ordered (February 13, 2015)...Intervention: Pramipexole Dihydrochloride 0.25 mg (milligram) 1 tab (tablet) by po (mouth) QHS (at bed time) DX (diagnosis): RLS (restless leg syndrome)..."

The nurse responsible for administering pramipexole dihydrochloride to Resident #11 on 3/28/16 was not available for interview.

On 5/5/16 at 7:30 a.m., an interview was conducted with LPN (licensed practical nurse) #9 regarding the facility process for ensuring medication availability. LPN #9 stated she tries to call the medication in to the pharmacy ahead of time (before the medication runs out). LPN #9 stated the medication card containing the pills tells staff if more medication remains on the prescription. LPN #9 stated she also checks the bottom of the medication cart because extra medications are stored there. LPN #9 stated the facility also has a STAT medication box as a backup in case a resident runs out of medication.

On 5/5/16 at 8:30 a.m., an interview was conducted with RN (registered nurse) #1 regarding the facility process for ensuring medication availability. RN #1 stated the cards containing the medications had an order sticker. RN #1 stated staff should remove the sticker from the card, place the sticker on the pharmacy refill order sheet and fax the refill order sheet to the pharmacy when five pills remain.

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Review of the facility STAT medication box list revealed the box did not contain pramipexole dihydrochloride.

The facility policy titled, "Medication Ordering and Receiving From Pharmacy" documented in part, "2. Medications refills are written on a medication order form/ordered by peeling the refill sticker portion of the label and placing it on the reorder sheet provided by the pharmacy for that purpose and ordered as follows: a. Quantities of medications sent from the pharmacy may vary in accordance with payer status, insurance plan, or law. Reorder medication five days in advance of need, as indicated by the reorder sticker, to assure an adequate supply is on hand..."

On 5/5/16 at 11:20 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

(1) This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011806/?report=details

F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

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The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

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The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility document review and in the course of a complaint investigation it was determined the facility staff failed to ensure the clinical records were complete and accurate for one of 29 Residents in the survey sample, Resident # 22. The facility staff failed to document a threat of self-harm in the clinical record for Resident # 22. Resident # 22 reported to facility staff (4/15/16 at approximately 3:10 p.m.) that: "She would have to find something to hurt herself if she could not be helped with the pain."

The findings include:

Resident # 22 was admitted to the facility on 11/20/15 with a recent readmission on 3/18/16 with diagnoses that included but were not limited to: anemia, atrial fibrillation, congestive heart failure, hypertension, gastroesophageal reflux disease, renal insufficiency, hyperlipidemia, thyroid disorder, depression, and diabetes.

The most recent MDS (minimum data set) assessment, a Significant Change Assessment, with an assessment reference date of 3/25/16, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating

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1. Resident #22 is no longer in the facility.
2. All residents have the potential to be affected by this deficient practice.
3. Nursing staff were educated by the Director of Nursing or Designee of the need to document all threats of self-harm in the clinical record.
4. On occurrence of threats of self-harm, Unit Managers or designee will audit documentation to assure that all events are recorded for twelve weeks. Results of audits will be taken to the QA for review and revision as needed monthly for three months.
5. Date of compliance: June 2, 2016.

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the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one person for all of her activities of daily living. Review of the three previous MDS assessments for Section D Mood documented the following: an admission assessment with an ARD of 11/27/15 documented a Total Severity Score of 1; a quarterly assessment with an ARD of 2/8/16 documented a Total Severity Score of 4; and a Significant Change Assessment with an ARD of 3/25/16 documented a Total Severity Score* of 6. Review of the previous three MDS assessments for Section E Behavior documented the following: an admission assessment with an ARD of 11/27/15 documented a no behaviors; a quarterly assessment with an ARD of 2/8/16 documented no behaviors; and a Significant Change Assessment with an ARD of 3/25/16 documented no behaviors.

*Total Severity Score is a summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists. CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) MDS 3.0 Manual page D-8.

During an interview on 5/5/16 at 9:40 a.m. with OSM (other staff member) #10, an assistant in the business office, OSM # 10 reported that on 4/15/16 at approximately 3:10 p.m. while he was conducting room rounds Resident # 22 reported to him that she was in a lot of pain. OSM # 10 stated the resident's pain was in both of her legs. OSM # 10 further stated that he told the resident

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that he would check with the nurse (about pain medication). OSM # 10 stated that resident # 22 threatened to harm herself, "She would have to find something to hurt herself if she could not be helped with the pain." OSM # 10 said he told the resident, "No, don't do that; let me talk to the nurse and see if they can get you something for the pain." OSM # 10 then stated he went to Resident # 22's nurse [LPN (licensed practical nurse) # 15] and told him that she was in pain. OSM # 10 stated he did not remember telling the nurse about the threat only about the pain but when he returned from rounds to hand in his papers for rounds he definitely told RN (registered nurse) # 3, MDS nurse, and OSM # 12, a social worker, about Resident # 22's pain and her threat to hurt herself. OSM # 10 stated that he told the nurse (LPN # 15) only about the pain; this was confirmed in another interview with OSM # 10 on 5/5/16 at 11:30 a.m.

Review of the clinical record did not reveal any documentation of Resident # 22's threat of self-harm prior to the resident harming herself.

The only nurse's note concerning the resident is the note below that was written after, she (Resident # 22) harmed herself and the note did not document the Resident's threat of self-harm prior to the incident as noted in the interview above with, OSM # 10.

Review of the clinical record revealed the following documentation: "Nursing Note, 4/15/16 22:23 (10:23 p.m.) Note Text: @ (at) 1531 (3:30 p.m.) resident called for pain med and oxycodone** 5 mg was given to resident. CNA (certified nurse's assistant) notified writer @ 1645 (4:45 p.m.) that resident had stabbed herself with

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scissors. Writer noted scissors in residents left abdominal area with blood seeping from area. Writer then covered area with gauze. Writer left the room immediately and called for more help leaving two care givers to assist in monitoring resident while ADON (assistant director of nurses - ASM # 3), MD (Medical doctor - ASM # 4), Unit Manager (RN # 4) were called into the room immediately 911 were immediately notified @ 1647 (4:47 p.m.) resident asked for pain med (medication) and morphine 0.25 mg (milligram) was given. Vitals were obtained (bp - 123/68, p - 73, t - 98.8, r - 18). RP (responsible party) notified @ 1655 (4:55 p.m.), voicemail left and call was returned @ 1725 (5:25 p.m.) and @ 1653 (4:56 p.m.), At home care made aware. 911 arrived, resident was then transported to (name of local hospital). @ 2145 (9:45 p.m.), (name of local hospital) called back that resident was coming back. At this time, resident is not in the building yet." Note: bp - blood pressure, p - pulse, t - temperature, r - respirations.

During an interview on 5/5/16 at 10:23 a.m., with RN (registered nurse) # 3, the MDS (minimum data set) coordinator, RN #3 related the events of 4/15/16 as she remembered them. RN #3 stated rounds are done at the beginning of the day and at the end of the day. It was about 3:30 p.m. and (Name of OSM # 12, the social worker) was in the room when (name of OSM # 10, staff member that the threat was reported to) was reporting his findings. OSM # 10 stated that (name of Resident # 22) was in a lot of pain in her legs and that she needed something for pain. He further stated the resident stated that if she could not get something she might hurt herself. OSM # 10 told her (RN # 3) that he told the nurse (LPN # 15) about (name of Resident # 22's) pain and the

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nurse stated the resident had just had something for pain. He (OSM # 10) could only remember that he told the nurse (LPN# 15) that resident was requesting something for pain but not about the threat to hurt herself. RN # 3 stated OSM # 12 was present for this conversation. During another interview on 5/5/16 at 1:00 p.m. (concerning events of 4/15/16) with RN # 3, RN # 3 repeated that she knew about the threat and that OSM # 12 was in the room when OSM # 10 reported the threat. RN # 3 stated that others in the room, whom she could not identify, stated that the Unit Manager (RN #4) and the physician (ASM # 4) were in the Resident's room. RN # 3 stated OSM # 12, the social worker got up and left the room, although RN # 3 did not know where OSM # 12 was going and did not ask. RN # 3 stated, "I thought (name of OSM # 12) was going down to see her (Resident # 22) when she left the room." She (RN # 3) stated she thought everything was being addressed but did not go down there to make sure. When asked if she knew how Resident #22 got the scissors, she stated that she did not.

During an interview on 5/5/16 at 10:04 a.m. with OSM # 12, the social worker, OSM # 12 related what she remembered: When she (OSM # 12) got to the "stand down meeting" at 3:30 p.m. (on 4/15/16) (names of RN # 3 and OSM # 10) were in the room. OSM # 12 reported that she heard OSM # 10 was saying (name of Resident # 22) made a statement she (Resident # 22) wished she was dead because she was in so much pain. OSM # 12 understood OSM # 10 to say he had already notified nursing about the pain and she (OSM # 12) understood that nursing was down there (in the resident's room) assessing the Resident's pain. OSM # 12 also stated there was

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a distinction between the resident stating "I wish I was dead" and "I am going to find something to hurt myself" they are not the same. OSM #12 stated, "If the resident had said, 'I'm going to hurt myself, I would have acted immediately." When asked if she (OSM # 12) went down to see the resident OSM # 12 stated, "I did not physically go down and see the resident."

During an interview on 5/5/16 at 1:25 p.m. with OSM # 12, OSM # 12 again repeated that, "I wish I was dead was not a statement of self-harm."

Review of the clinical record revealed a "Social Services Note dated 4/16/16 at 15:23 (3:23 p.m.) (the day after the incident)." This note documented the SW (social worker - OSM # 12) was following up on Resident # 22 and if she (Resident # 22) intended to harm herself. There was no note prior to this note documenting that the social worker was monitoring the resident for threats of self-harm. There was no documentation evidenced in the clinical record of notification to the administrator, director of nursing physician of the residents comment of self harm. There was no documentation of an assessment for and or interventions implemented in response to the resident's statement for self harm.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 05/05/201

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPLE DAT
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track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."

Prior to exit no further documentation was provided.

COMPLAINT DEFICIENCY